

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09908

CERTIFICATE OF DEATH

09869

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Convalescent Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Edwards</u> Last <u>Adams</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 10, 1889</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR: Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>		IF UNDER 24 HRS. <u>70</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Charleston S. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>							
13. FATHER'S NAME <u>John J. Edwards</u>				14. MOTHER'S MAIDEN NAME <u>Mary Louise Teasdale</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>Wm. B. Adams 7818 Ballston Rd #4</u>			
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio Vascular Disease</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>443X</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 15</u> , 19 <u>50</u> , to <u>Sept 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 17</u> , 19 <u>59</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Laurence C. Post</u> M.D. <u>6805 York Rd.</u>				DATE SIGNED <u>9/17/59</u>			
PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST - Baltimore</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/19/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson Inc</u> ADDRESS <u>1050 York Rd. Towson</u>				24a. REC'D BY REGISTRAR <u>SEP 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

10000

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH RECORD

CERTIFICATE OF DEATH

10000

<p>NAME OF DECEASED</p>		<p>AGE</p>		<p>SEX</p>		<p>RACE</p>		<p>DATE OF BIRTH</p>		<p>PLACE OF BIRTH</p>	
<p>RESIDENCE</p>		<p>DATE OF DEATH</p>		<p>PLACE OF DEATH</p>		<p>CAUSE OF DEATH</p>		<p>PERIOD OF ILLNESS</p>		<p>PREVIOUS ILLNESS</p>	
<p>EDUCATION</p>		<p>RELIGION</p>		<p>MARRIAGE</p>		<p>PROFESSION</p>		<p>INDUSTRY</p>		<p>REMARKS</p>	
<p>SIGNATURE OF DECEASED</p>		<p>SIGNATURE OF WITNESSES</p>		<p>SIGNATURE OF PHYSICIAN</p>		<p>SIGNATURE OF CLERK</p>		<p>SIGNATURE OF REGISTRAR</p>		<p>SIGNATURE OF JUDGE</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09909

CERTIFICATE OF DEATH

09870

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 205 Garden Ridge Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OLIVE Middle DONZELLA Last ALT		4. DATE OF DEATH Month Sept. Day 10, Year 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1895
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - self Emp.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry W. Vogt		14. MOTHER'S MAIDEN NAME Annie Romoser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Russell Conklin - 416 Oak Forest Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis to Liver 153.8 DUE TO from Carcinoma of colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months 21 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec , 19 49 to 9/10 , 19 59 , that I last saw the deceased alive on 9/6 , 19 59 , and that death occurred at 2 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Martin E. Singewald M.D.		ADDRESS (Street, city or town, state) 11 E. Chase St Baltimore Md	
PHYSICIAN'S NAME (Type) MARTIN E. SINGEWALD		DATE SIGNED 9/10/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/12/59	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	22d. LOCATION (City, town, or county) (State) Woodlawn, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Schenker & Sons - Baltimore		24a. REC'D BY REGISTRAR SEP 11 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Virgil A. Huns	

CERTIFICATE OF DEATH

1910

MASSACHUSETTS
DEPARTMENT OF HEALTH
BOSTON

1. Name of deceased: *John J. Smith*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *Jan 15 1910*

5. Place of death: *Home*

6. Cause of death: *Heart Disease*

7. Signature of physician: *Dr. J. H. Smith*

8. Signature of registrar: *John J. Smith*

9. Date of registration: *Jan 15 1910*

10. Place of registration: *Boston*

1
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TSM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09910

CERTIFICATE OF DEATH

Reg. Dist. No.

09871

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
c. LENGTH OF STAY IN 1b 1 1/2 months		d. STREET ADDRESS 2907 Spellman Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harriet Middle Mary Last Anderson		4. DATE OF DEATH Month 9 Day 10 Year 19 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/24/58
9. AGE (In years last birthday) yrs. 11 Months 11 Days 14		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours 14 Min. 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland (BALTO.)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul Anderson		14. MOTHER'S MAIDEN NAME Mary Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. INFORMANT Address Rosewood Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 500X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. Acute Bronchitis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9/2/59 9/2/59	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Non-communicative Hydrocephalus, congenital - birth			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/2/59 , 19 59 , to 9/10/59 , 19 59 , that I last saw the deceased alive on 9/10/59 , 19 59 , and that death occurred at 8:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry G. Butler		M.D. Rosewood Training School DATE SIGNED 9/10/59	
PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		Owings Mills, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-14-59	
22c. NAME OF CEMETERY OR CREMATORY Int Calvary Cem		22d. LOCATION (City, town, or county) (State) A. D. C. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O Wilson		ADDRESS 21 50	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Chas E. Hunt	

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Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

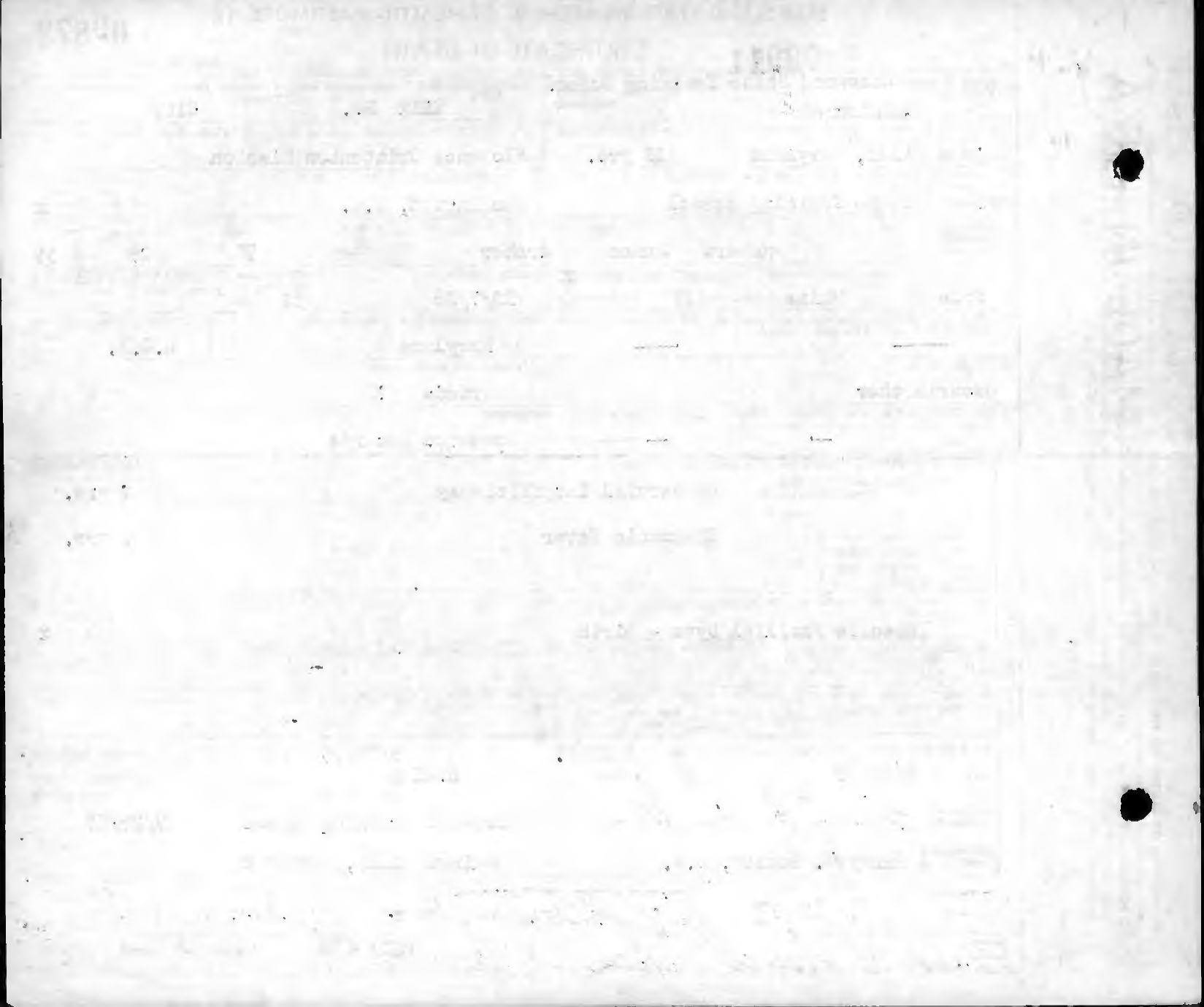
09872

09911

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland c. LENGTH OF STAY IN 1b 25 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE EXX Md. b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Florence Crittenton Mission d. STREET ADDRESS 3111 Blue Ridge e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle James Last Archer		4. DATE OF DEATH Month 9 Day 29 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/7/26
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months 3 Days 1 Hours 4 Min.	IF UNDER 24 HRS. Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Oscar Archer	
14. MOTHER'S MAIDEN NAME Frieda ?		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. —		INFORMANT Rosewood Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 415X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Rheumatic Fever DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Imbecile Familial type - Birth			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 9/28/59 , 19 59 , to 9/29/59 , 19 59 , that I last saw the deceased alive on 9/29/59 , 19 59 , and that death occurred at 6:00 AM , from the causes and on the date stated above.	
ACTUAL SIGNATURE Harry G. Butler		ADDRESS (Street, city or town, state) Rosewood Training School DATE SIGNED 9/29/59	
PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		Owings Mills, Maryland	
22a. BURIAL CREMATION, REMOVAL (Specify) 9. 30. 59	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATOR	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Frank D. Newell		24a. REC'D BY REGISTRAR Oct 2 59 DATE	
24b. REGISTRAR'S SIGNATURE Arthur A. Francis			



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09913

CERTIFICATE OF DEATH

09874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland c. LENGTH OF STAY IN 1b 7 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland d. STREET ADDRESS 311 Locust Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lawrence Middle LaMonaco Last Armiger			4. DATE OF DEATH Month 9 Day 8 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/21/47	9. AGE (In years last birthday) 12 yrs.	IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min. 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME William Paul Armiger			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. ---			
17. INFORMANT Rosewood Records			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Em pyemia of right pleural cavity 491X DUE TO bilateral bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)		(County)		(State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:15p , from the causes and on the date stated above.						
ACTUAL SIGNATURE Peter W. Rieckert		ADDRESS (Street, city or town, state) 4307 Maryland Ave Baltimore 14, Md.				
DATE SEP 10 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-10-59		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		
22d. LOCATION (City, town, or county) Baltimore, Md.		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck ADDRESS 5305 Harford Rd.						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09873

CONRAD A. ATKINSON

CERTIFICATE OF DEATH

Reg. Dist No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>		c. LENGTH OF STAY IN 1b <i>28</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>10 Park Drive</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Conrad A. Atkinson</i>		4. DATE OF DEATH <i>Sept. 5 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/13/83</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Catholic rev.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Newspaper</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Atkinson</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Ellis</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes, give war or dates of service</i>		16. SOCIAL SECURITY NO. <i>Margaret Atkinson</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.1</i> DUE TO (b) <i>Arteriosclerosis C.V.P.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <i>instant</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3/15 1958</i> to <i>9/5 1959</i> that I last saw the deceased alive on <i>9/5 1959</i> , and that death occurred at <i>10</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. C. Pounce</i> M.D.		ADDRESS (Street, city or town, state) <i>3325 Fredericka</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>J. C. Pounce</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>9/8/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>	22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur L. Kenna</i> ADDRESS <i>28</i>		24a. REC'D BY REGISTRAR <i>SEP 9 '59</i> DATE	
		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kenna</i>	



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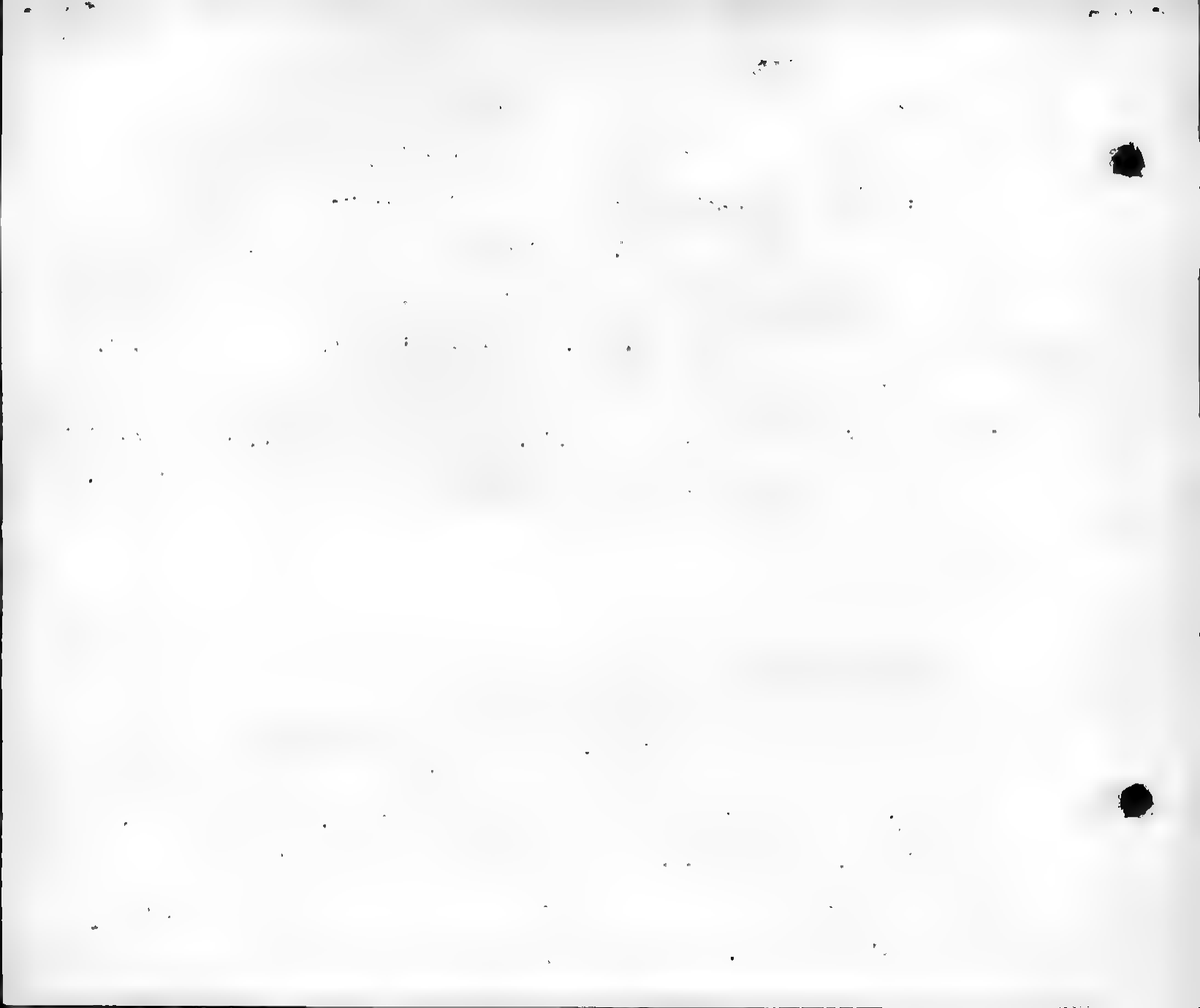
09875

09914

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN TB 6 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore(12)		d. STREET ADDRESS 822 Kingston Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First LLOYD		Middle M.		Last BARGER	
4. DATE OF DEATH		Month September		Day 16		Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 18, 1898		9. AGE (in years last birthday) 60 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY VA RO US.Govt.		11. BIRTHPLACE (State or foreign country) Kansas City, Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert H. Barger				14. MOTHER'S MAIDEN NAME Mary Inez Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW I		INFORMANT Clin. Records, VAH, Balto, MD.		Address Fort Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 6 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. VA		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that John W. Crawford attended the deceased from September 10, 1959 to September 16, 1959 and that death occurred at 6:25A AM, from the causes and on the date stated above		ADDRESS (Street, city or town, state) VAH, BALTO 18, MD. FORT HOWARD DIV.		DATE SIGNED 9/16/59			
ACTUAL SIGNATURE John W. Crawford		M.D. VAH, BALTO 18, MD. FORT HOWARD DIV.		DATE SIGNED 9/16/59			
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH, FORT HOWARD, DIVISION		DATE SIGNED 9/16/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Sept. 21/59		22c. NAME OF CEMETERY OR CREMATORY Hill Crest		22d. LOCATION (City, town, or county) (State) Fulton, Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc.		ADDRESS 1050 York Rd. Towson		24a. REC'D BY REGISTRAR SEP 21 '59		24b. REGISTRAR'S SIGNATURE Arthur B. Hines	



09915

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>4 mo 7</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Paradise Nursing Home</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>			
f. STREET ADDRESS <u>911 Middlesex Rd.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Henry W. Barrett, Sr.</u>				4. DATE OF DEATH <u>9</u> Month <u>23</u> Day <u>1959</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/23/1895</u>	
9. AGE (In years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>For Self</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>✓</u>			
17. INFORMANT <u>Mr. Edward R. Krickham</u> Address <u>2112 Ave</u>				18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4a0.1</u> DUE TO <u>Coronary Thrombosis with Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2</u> DUE TO <u>Hemiplegic left old</u> (c) <u>3</u> DUE TO <u>Amputation Mid thigh left.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>9/23/59</u>				20g. (County) <u>9/23/59</u>		20h. (State) <u>9/23/59</u>	
21. I certify that I attended the deceased from <u>9/23/59</u> to <u>9/23/59</u> , that I last saw the deceased alive on <u>9/23/59</u> and that death occurred at <u>7:40 PM</u> from the causes and on the date stated above				ADDRESS (Street, city or town, state) <u>1303 Frederick Rd</u> DATE SIGNED <u>9/24/59</u>			
ACTUAL SIGNATURE <u>W E Mc Grath</u> M.D.				PHYSICIAN'S NAME (Type) <u>W E Mc Grath</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Haven Cem.</u>	
22d. LOCATION (City, town, or county) <u>Potomac</u>				22e. (State) <u>md</u>		22f. (Country) <u>USA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u>				ADDRESS <u>9 Hoelous St.</u>		24a. REC'D BY REGISTRAR <u>SEP 25 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton A. Hunt</u>				24c. (City or town) <u>Catonsville</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
JSM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09902 CERTIFICATE OF DEATH

Reg. Dist. No.

09877

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1013 Linden Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Nelson Last Barry		4. DATE OF DEATH Month September Day 10 Year 1959	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1897
9. AGE (In years last birthday) 62 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retire		10b. KIND OF BUSINESS OR INDUSTRY B & O R.R. Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.A.	
13. FATHER'S NAME John J. Barry		14. MOTHER'S MAIDEN NAME Margaret Cavanaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO 705 12-5914	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 16d.1 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchiogenic Carcinoma DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Pulmonary Tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1, 1957 , to 9/10, 1959 , that I last saw the deceased alive on 9/10, 1959 , and that death occurred at 8:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James Frederick, M.D.		ADDRESS (Street, city or town, state) 1305 Francis Avenue Balto. 27, Md.	
PHYSICIAN'S NAME (Type) James Frederick, Md.		DATE SIGNED SEP 14 '59	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 9/14/59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		24a. REC'D BY REGISTRAR SEP 14 '59	
ADDRESS 4107 Wilkens Avenue		24b. REGISTRAR'S SIGNATURE Arthur A. Kline	



09916

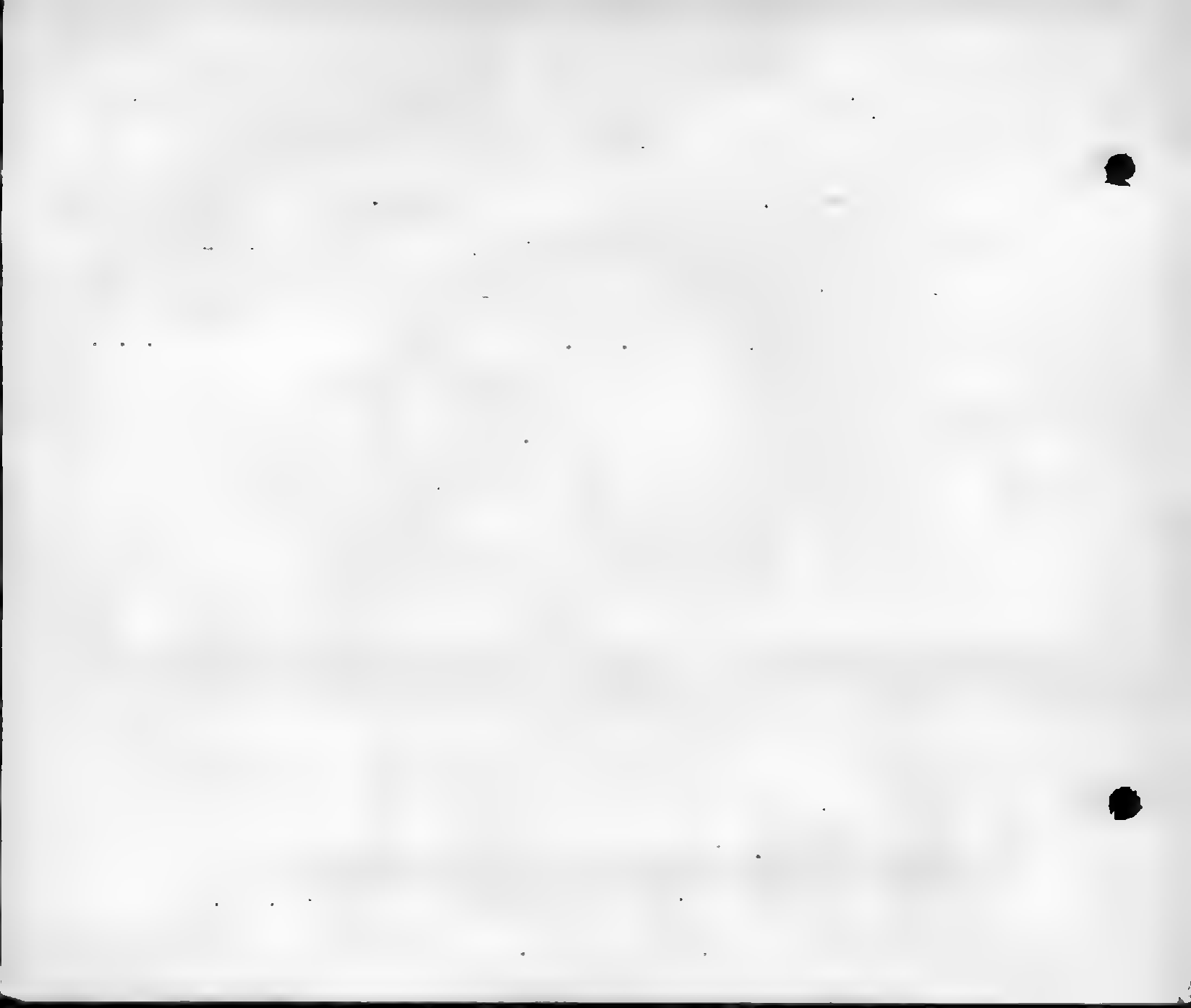
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION York Rd.		d. STREET ADDRESS York Rd.	
3 NAME OF DECEASED (Type or print) First Esther Middle Keckner Last Barshinger		4. DATE OF DEATH Month 9 Day 12 Year 59	
5 SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-1886
9 AGE (In years last birthday) 73 yrs		10. UNDER 1 YEAR IF UNDER 24 HRS Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone operator		10b. KIND OF BUSINESS OR INDUSTRY Tel. Co.	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adam Keckner		14. MOTHER'S MAIDEN NAME Sarah Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-0324	
17. INFORMANT Mrs. Edna Burke,		Address above	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Gen. Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Rheumatic Heart Disease DUE TO Childhood		INTERVAL BETWEEN ONSET AND DEATH 5 yrs ?	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1938, to 9-12- , 1959, that I last saw the deceased alive on 9-12- , 1959, and that death occurred at 2 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 3105 N. Charles St. Baltimore, 18. 94A DATE SIGNED _____			
ACTUAL SIGNATURE Robert H. Siver		M.D. 3105 N. Charles St. Baltimore, 18. 94A	
PHYSICIAN'S NAME (Type) Robert H. Siver			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-15-59	22c. NAME OF CEMETERY OR CREMATORY Lessop Methodist	22d. LOCATION (City, town, or county) (State) Sparks, Md.
23 FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.		24a. REC'D BY REGISTRAR DATE SEP 15 '59	
		24b. REGISTRAR'S SIGNATURE Arthur E. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BATHGATE 09917 CERTIFICATE OF DEATH

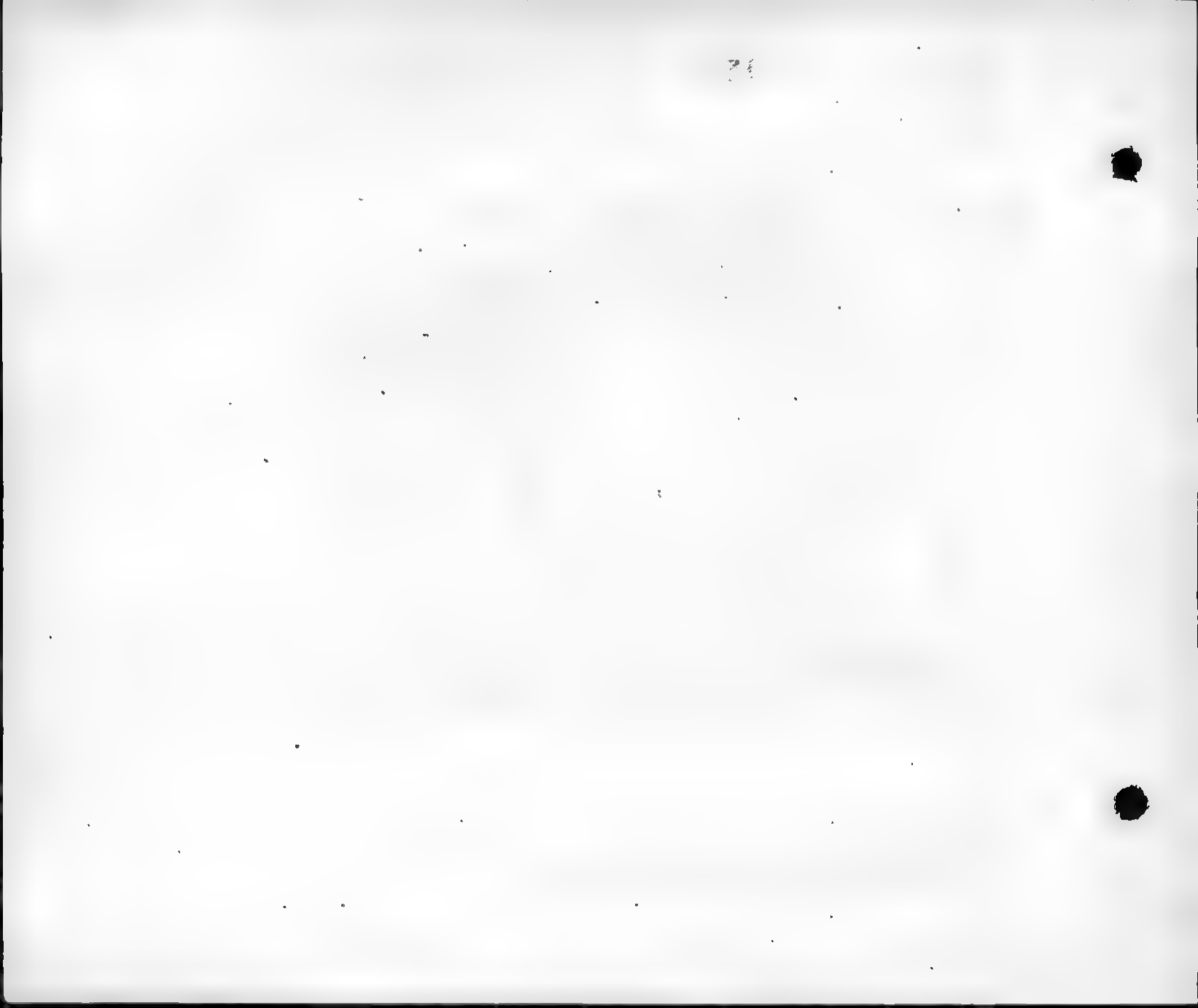
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. LENGTH OF STAY IN 1b <u>2 WK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		d. STREET ADDRESS <u>192 Brady St. Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Gertrude Bathgate</u>		4. DATE OF DEATH Month <u>9</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/16/93</u>
9. AGE (In years last birthday) <u>61</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	11. IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. RR.</u>	11. BIRTHPLACE (State or foreign country) <u>Ind.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Amos Bathgate</u>	
14. MOTHER'S MAIDEN NAME <u>Marah Parnell</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Dr. Dancy Mesche</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>241X Branchial asthma + emphysema</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> , 19 <u> </u> to <u>9-9-59</u> , 19 <u> </u> , that I last saw the deceased alive on <u>9-9-59</u> , 19 <u> </u> , and that death occurred at <u>7:57 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John A. Neffitt Jr.</u> M.D. <u>1118 St Paul St</u>		DATE SIGNED <u>9-9-59</u>	
PHYSICIAN'S NAME (Type) <u>JOHN A. NEFFITT JR.</u>		<u>Baltimore 2, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/12/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Vincent</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Neffitt + Son</u> ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR <u>SEP 14 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur A. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

09918

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Pennsylvania b. COUNTY York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover 75 x 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 44 Baltimore Street	
3. NAME OF DECEASED (Type or print) First EDWARD Middle LEROY Last BAUMGARDNER		4. DATE OF DEATH Month September Day 14 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1918
9. AGE (In years (say birthday) yrs) 41		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jeweler		10b. KIND OF BUSINESS OR INDUSTRY Owner of Shop	
11. BIRTHPLACE (State or foreign country) Hanover, Pennsylvania		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME David Baumgardner		14. MOTHER'S MAIDEN NAME Martha J. Barnhart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO 207 -03-7321	
17. INFORMANT Clin. Records, VAH, Balto. 18, Md., Fort Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOID, LIVER XX METASTATIC CARCINOID, MESENTERIC AND RETRO- PERITONEAL LYMPH NODES (c) PULMONARY CONGESTION AND EDEMA		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. (Operation) Surgical absence, lower colon & rectum. 2. Colostomy (Operation)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 21, 1959 , to September 14, 1959 , and that death occurred at 6:30 A. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Crawford, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED VAH, Baltimore, Md. Fort Howard Div. 9/14/59	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH, Balto. 18, Md. Fort Howard, Div. 9/14/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9-17-59	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hanover, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Son		ADDRESS Princeton St., Reisterstown, Md.	
24a. REC'D BY REGISTRAR DATE SEP 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

and

rd, Div. 2

rd Div. 2/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

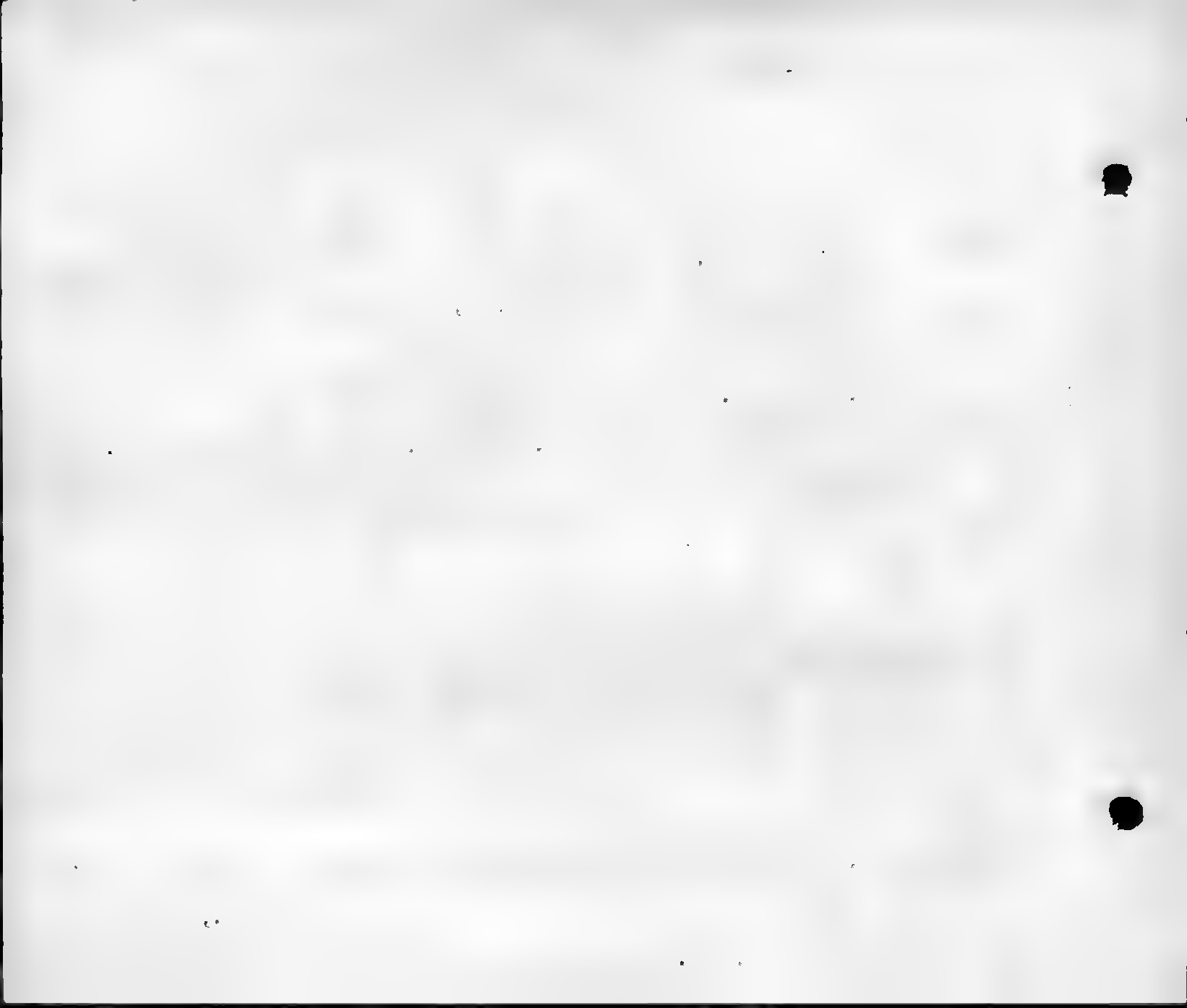
09919

CERTIFICATE OF DEATH

05881

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison		c. LENGTH OF STAY IN 1b 83 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Foxleigh Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First ROBERT Middle W. Last BEACH		4. DATE OF DEATH Month September Day 21 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1901
9 AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert W. Beach, Sr.		14. MOTHER'S MAIDEN NAME Mary Cunningham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Frances M. Beach		Address Westminister, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Rectum DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) General Metastasis			INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 19 56 , to Sept 21 , 19 59 , that I last saw the deceased alive on Sept 20 , 19 59 , and that death occurred at 8:30 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Palmer F. Williams, M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. Palmer Williams		1725 Reisterstown Road Pikesville 8, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/22/59	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge	22d. LOCATION (City, town, or county) (State) Pikesville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	
ADDRESS 1900 Eutaw Place		DATE SEP 23 '59	



VS. AISME(S)
SM 9/55

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

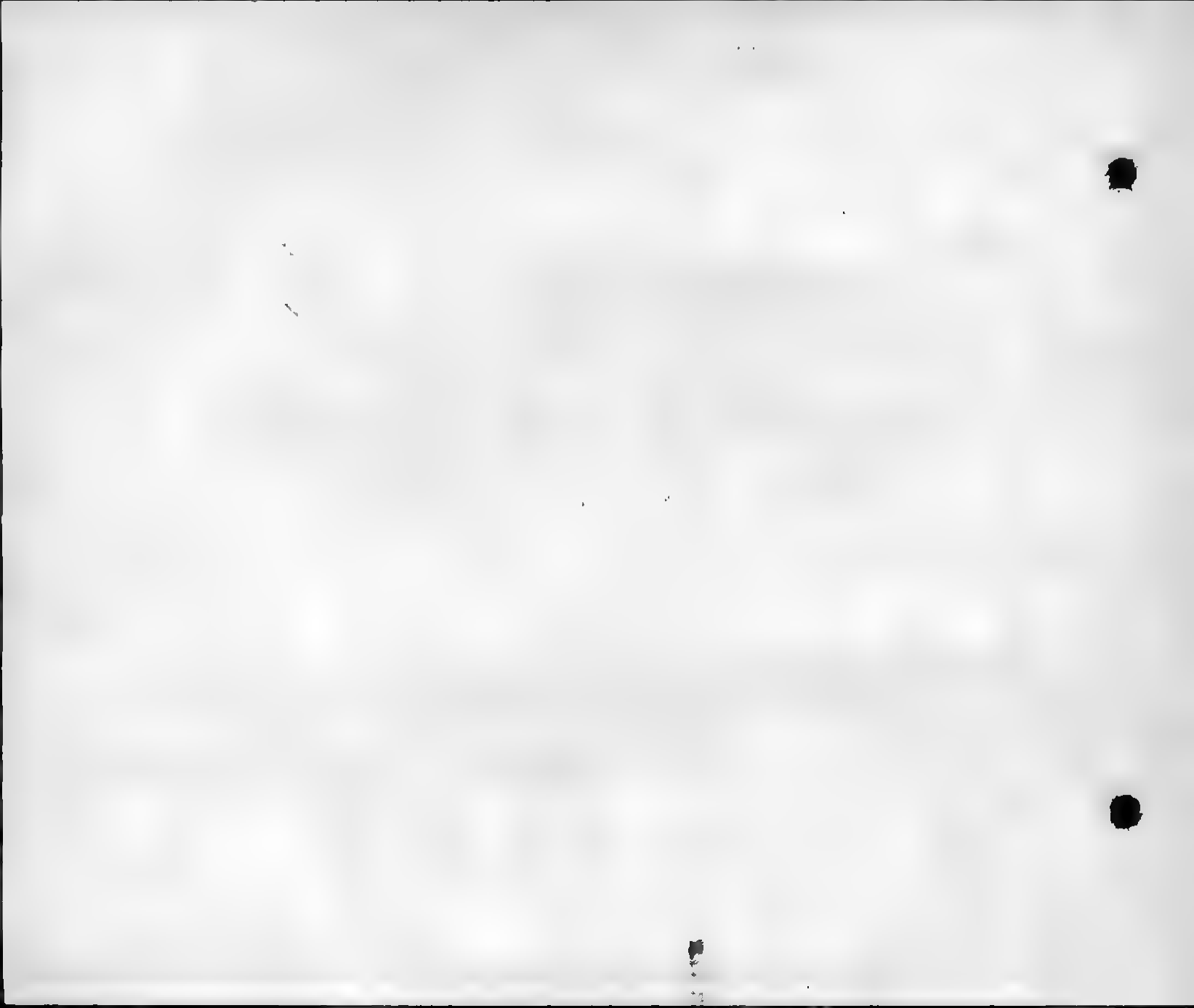
09393

Item 9 filmG248 9-18-59 e.

Reg. Dist. No.

09882

1. PLACE OF DEATH a. COUNTY BALTO		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK	c. LENGTH OF STAY IN Id 21 YRS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3 DUNDALK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3113 CORNWALL Rd	d. STREET ADDRESS 3113 CORNWALL Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET MCKEE BEAMAN.		4. DATE OF DEATH Month Day Year SEPT 8 1957	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/1912
9. AGE (In years last birthday) 46		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOLS	11. BIRTHPLACE (State or foreign country) PENNA
12. CITIZEN OF WHAT COUNTRY? U.S. IA			
13. FATHER'S NAME EDWIN B. MCKEE		14. MOTHER'S MAIDEN NAME ELIZABETH CRANDELL MCKEE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NC		16. SOCIAL SECURITY NO. 166-14-326X	
17. INFORMANT JOHN F. BEAMAN - SAME		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work Not while at work <input checked="" type="checkbox"/> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M.B. Davis		DATE SIGNED 9/9/59	
EXAMINER'S NAME (Type) M.B. DAVIS M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/11/59	
22c. NAME OF CEMETERY OR CREMATORY MORELAND		22d. LOCATION (City, town, or county) (State) BALTO. Co., md	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Lingo Rudolph, Dundalk Md		24. REC'D BY REGISTRAR DATE SEP 11 '59	
24b. REGISTRAR'S SIGNATURE Collins & Evans			



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09920

CERTIFICATE OF DEATH

09883

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>1858 E Battle Grove Ave</u>		d. STREET ADDRESS <u>1858 E Battle Grove Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Diana</u> Middle <u>Lynne</u> Last <u>Bennett</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1952</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>6</u>
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emanuel Bennett</u>		14. MOTHER'S MAIDEN NAME <u>Edna Louise Ritchie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Emanuel Bennett</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neuroblastoma, left kidney</u> <u>180x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>14 mos</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. <u>19</u> Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 1958</u> , to <u>Sept. 27, 1959</u> , that I last saw the deceased alive on <u>Nov. 1958</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R Donald Jandorf</u>		M.D. <u>6077 Harford Rd.</u> DATE SIGNED <u>9-27-59</u>	
PHYSICIAN'S NAME (Type) <u>R Donald Jandorf</u>		<u>Balto. 14, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/30/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Brandywine, West Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles A. Thane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

M

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VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05884

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7925 Berk Lane</u>		d. STREET ADDRESS <u>7925 Berk Lane</u>	
3. NAME OF DECEASED (Type or print) <u>SADIE</u>		4. DATE OF DEATH Last <u>BERK</u> Month <u>9</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 9, 1904</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR: Months <u>55</u> Days <u>19</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Binder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waverly Press</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Godfrey Berk</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Wadl</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-10-1604</u>	
17. INFORMANT <u>Catherine Grant</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>---</u> (c), stating the underlying cause last. DUE TO (c) <u>---</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>---</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>---</u> p.m. <u>---</u> 19 <u>---</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>---</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. Fisher M.D.</u> M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>---</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-21-59</u>	
Address (Street, city, town, or county) <u>---</u>		22a. BIRTH, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>Sept. 23, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Evan. Lutheran</u>	
22d. LOCATION (City, town, or country) (State) <u>Stenners Run, Md.</u>		23. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>	
ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR <u>SEP 23 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		DATE <u>SEP 23 '59</u>	



09922

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED

(Type or Print)

Blake, Miss Lucy Groverman

2. DATE OF DEATH

Sept 29 1959

3. PLACE OF DEATH

a. Baltimore City, Maryland 615 Chestnut Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1215 Eutaw Place

B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION) Tawson H. Md.

Aged Miss Woman Name

Yrs.
Mos.
Days

c. Length of stay in Baltimore

5 SEX

Female white

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Nov. 22, 1868 90 10 10

9. AGE (In years last birthday)

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Practical Nurse

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Calvert County, Md

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Joseph Blake

14. MOTHER'S MAIDEN NAME

Elizabeth Blake

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Daisy E. Sammis 615 Chestnut

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Hypostatic Pneumonia

4 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

arteriosclerotic Cardiovascular

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from . . . Nov . . . 19 . . . to . . . Sept 29 . . . 19 . . . that (I) (we) last saw the deceased alive on . . . Sept 27 . . . 19 . . . and that death occurred at 5:05 P m., from the causes and on the date stated above.

23A. SIGNATURE

Whitland E. Day

23B. ADDRESS

4-E-33rd St Baltis

23C. DATE SIGNED

Sept 29, 1959

24A. BURIAL, CREMATION, REMOVAL (Specify)

REMOVAL

24B. DATE

9-30-59

24C. NAME OF CEMETERY OR CREMATORY

All Saints Cemetery

24D. LOCATION (City, town, or county)

Calvert County, Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William E. Kline

25. FUNERAL DIRECTOR

ADDRESS

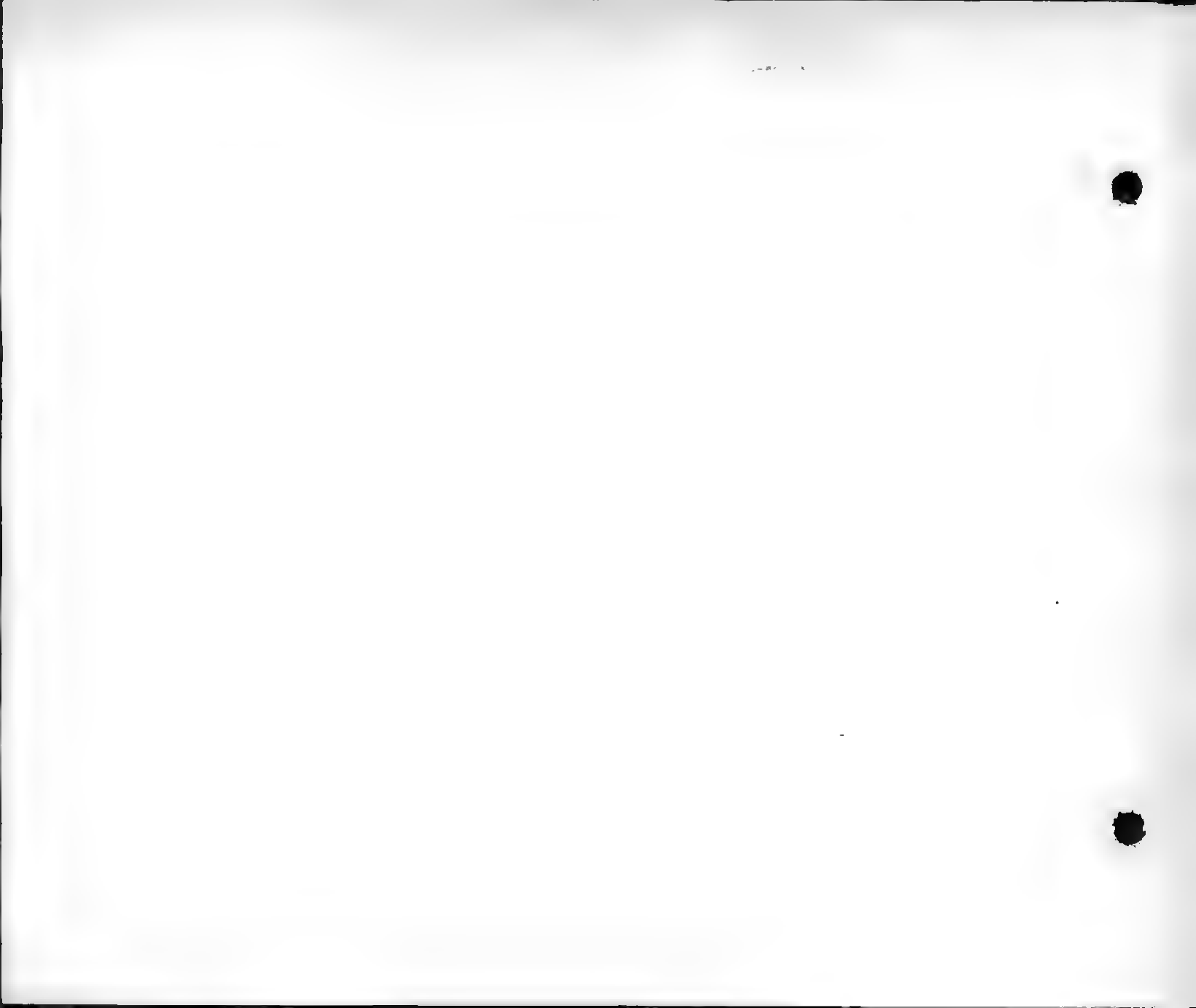
William Cook, Inc., 1217 St. Paul Street

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. This certificate must be filed with the BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER DEATH.

ML CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. TEL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09885

09923

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 13yr3mth9dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle Block Last		4. DATE OF DEATH Month September Day 4 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1889
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? Lithuania	
13. FATHER'S NAME Abraham sheer		14. MOTHER'S MAIDEN NAME Yetta Ania	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) Arteriosclerotic cardiovascular disease (c) Generalized arteriosclerosis	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1956 to Sept. 4, 1959 , that I last saw the deceased alive on Sept. 4, 1959 , and that death occurred at 12:30am , from the causes and on the date stated above			
ACTUAL SIGNATURE Stella Wachslar M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9-4-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-6-1959	22c. NAME OF CEMETERY OR CREMATORY Prosedale	22d. LOCATION (City, town, or county) (State) Catonsville Md.
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis ADDRESS 2100 Eutaw Place		24a. REC'D BY REGISTRAR SEP 8 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

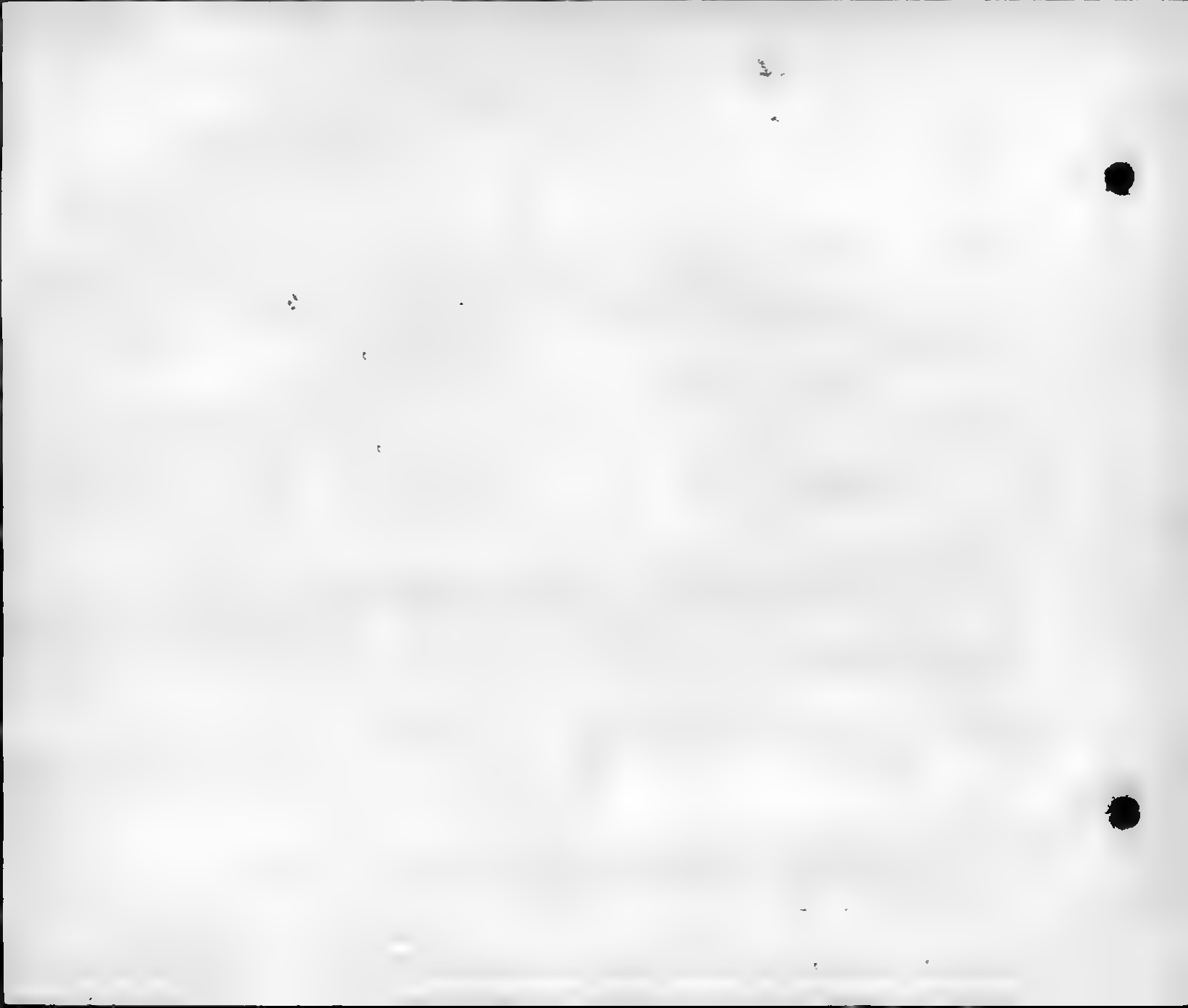
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09924 CERTIFICATE OF DEATH

09886

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The House in The Pines		d. STREET ADDRESS Marlborough Apt Eutaw Place & Wilson Street	
3. NAME OF DECEASED (Type or print) Hattie First T Middle Blumberg Last		4. DATE OF DEATH Sept 26 1959 Day 26 Month Sept Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 14, 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 12 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Tannebaum		14. MOTHER'S MAIDEN NAME Hannah Rider	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 	
17. INFORMANT Marlborough Apt Simon Blumberg, Eutaw Pl & Wilson St		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Gen. ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY: Hour a. 11 p. m. Month 19 Day Year 		20d. INJURY OCCURRED: While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from May 1959 to Sept. 26 1959 , that I last saw the deceased alive on Sept 26 1959 , and that death occurred at 1:15 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Daniel Bakal M.D.		ADDRESS (Street, city or town, state) 3600 Lochearn Dr. Balto. 7, Md	
PHYSICIAN'S NAME (Type) DANIEL BAKAL, M.D.		DATE SIGNED Sept 26, 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-28-59	22c. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew Cem	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE David R. Martin ADDRESS 1902 Eutaw Place		24a. REC'D BY REGISTRAR SEP 29 59 DATE	24b. REGISTRAR'S SIGNATURE Arthur A. Thompson



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

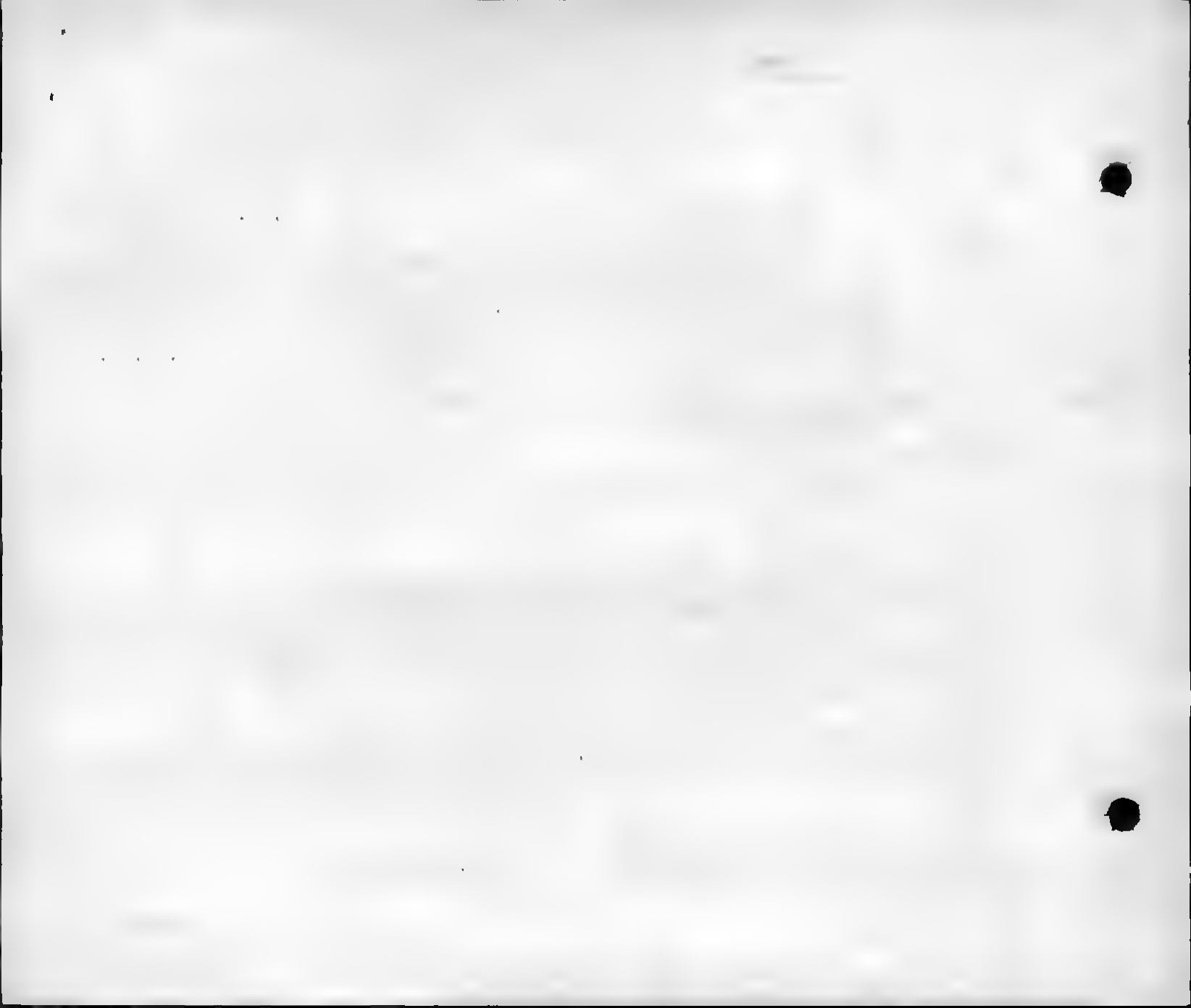
09887

09925

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) b. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Maryland	
c. LENGTH OF STAY IN 1b 3mthllyds		d. STREET ADDRESS 305 Third Avenue - S. E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Caroline Middle Henrietta Last Boessel		4. DATE OF DEATH Month Sept. Day 12 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1875
9. AGE (In years last birthday) yrs 84		IF UNDER 1 YEAR Months 12 Days 19 Hours 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown Henry Matzen		14. MOTHER'S MAIDEN NAME Unknown Katherine Giles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO 491A Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERAL DEBILITY DUE TO (c) GENERAL DEBILITY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERAL DEBILITY INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG. 21, 1959 to SEPT. 12, 1959 , that I last saw the deceased alive on SEPT. 12, 1959 , and that death occurred at 7:15 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED Sept. 12, 1959 ACTUAL SIGNATURE Patrick K. Yip M.D. PHYSICIAN'S NAME (Type) PATRICK K. YIP Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 15 Sept. 1959	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Richard V. Singleton		24a. REC'D BY REGISTRAR SEP 15 '59	
ADDRESS Glen Burnie, Md.		24b. REGISTRAR'S SIGNATURE C. L. Kline	



CERTIFICATE OF DEATH

09888

Reg. Dist. No.

09926

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 15 1mth22dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1306 James Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle Borgealt Last Borgealt				4. DATE OF DEATH Month September Day 22 Year 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 16, 1884	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work at Home				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U. S. A.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Joseph Borgealt				14. MOTHER'S MAIDEN NAME Carrie Nichols			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus ulcers							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 30 , 19 59 , to Sept. 22 , 19 59 , that I last saw the deceased alive on Sept. 22 , 19 59 , and that death occurred at 1:25a. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslers M.D. SPRING GROVE STATE HOSPITAL 9-22-59							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) Stella Wachslers, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		9/24/59		Not Olivet Cem.		2930 Frederick Ave	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Bowman				ADDRESS Rollins St.		24a. REC'D BY REGISTRAR DATE SEP 23 '59	
				24b. REGISTRAR'S SIGNATURE Arthur A. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove capers papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09927

CERTIFICATE OF DEATH

Reg. Dist. No.

09890

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 7 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 511 N. Mount Street (17) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First WILLIAM Middle S. Last BOWEN		4. DATE OF DEATH Month September Day 24 Year 19 59									
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 13, 1890	9. AGE (In years last birthday) yrs. 68	IF UNDER 1 YEAR Months 68	IF UNDER 24 HRS Days 68	Hours 68	Min 68			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Bakery Truck		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Joseph Bowen		14. MOTHER'S MAIDEN NAME Ella Waters		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		16. SOCIAL SECURITY NO. 212-14-2039		INFORMANT Clin. Records, VAH Baltimore, Md., Ft. Howard Div.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 522X PULMONARY EDEMA AND CONGESTION Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) PULMONARY EMPHYSEMA (c) ARTERIOSCLEROSIS, MARKED, GENERALIZED THROMBOSIS, RT. FEMORAL ARTERY WITH GANGRENE RIGHT LOWER EXTREMITY		INTERVAL BETWEEN ONSET AND DEATH Recent Unknown Unknown Unknown		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PYONEPHROSIS, LEFT KIDNEY. EMACIATION		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore		(State) Md.	
21. I certify that I attended the deceased from September 17 1959 , to September 24 1959 , and that death occurred at 1:00 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) VAH, BALTIMORE, MD., FT. HOWARD DIV.		DATE SIGNED 9/25/59		ACTUAL SIGNATURE John W. Crawford		M.D. VAH, BALTIMORE, MD., FT. HOWARD DIV.		PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-28-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland		22e. (State) Md.		23. FUNERAL DIRECTOR'S SIGNATURE A. Halstead	
24a. REC'D BY REGISTRAR SEP 28 1959		24b. REGISTRAR'S SIGNATURE A. Halstead		24c. DATE SEP 28 1959		24d. TIME 1:00 PM		24e. PLACE Baltimore, Md.		24f. COUNTY Baltimore	

ADOLPHUS HALSTEAD, 518 Druid Hill Ave., Balto., Md.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

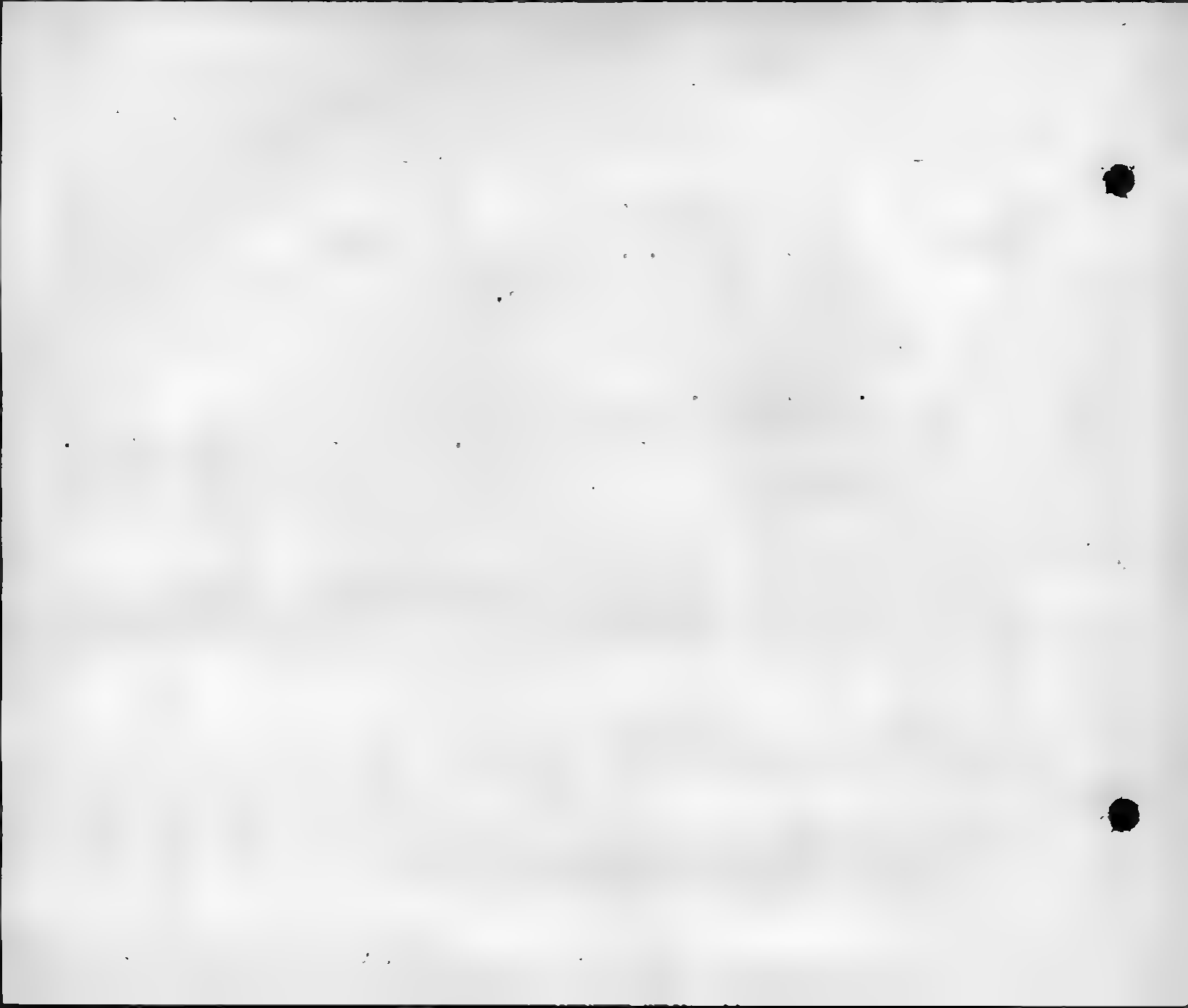
09928

CERTIFICATE OF DEATH

Reg. Dist. No.

09891

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1440 Providence Rd.				d. STREET ADDRESS 1440 Providence Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First RICHARD Middle N.S. Last BRITTON				4. DATE OF DEATH Month Sept. Day 26 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1906		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repair man		10b. KIND OF BUSINESS OR INDUSTRY Black and Decker		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward T. Britton, Sr.				14. MOTHER'S MAIDEN NAME Henrietta Morfoot			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tot. no. or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 212-10-9820		17. INFORMANT Hilda S. Britton-1440 Providence Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE LEUKEMIA (LYMPHOID) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE 8, 1959 to SEPT. 26, 1959 , that I last saw the deceased alive on SEPT. 24, 1959 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE T. C. Siwinski				ADDRESS (Street, city or town, state) 17 W. PENNA. AVE. MD. DATE SIGNED 9/28/59			
PHYSICIAN'S NAME (Type) T. C. SIWINSKI				TOWSON 4 MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/59		22c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gardens Timonium Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. 1050 York Rd. Towson				24a. REC'D BY REGISTRAR SEP 29 '59		24b. REGISTRAR'S SIGNATURE William H. Thrall	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

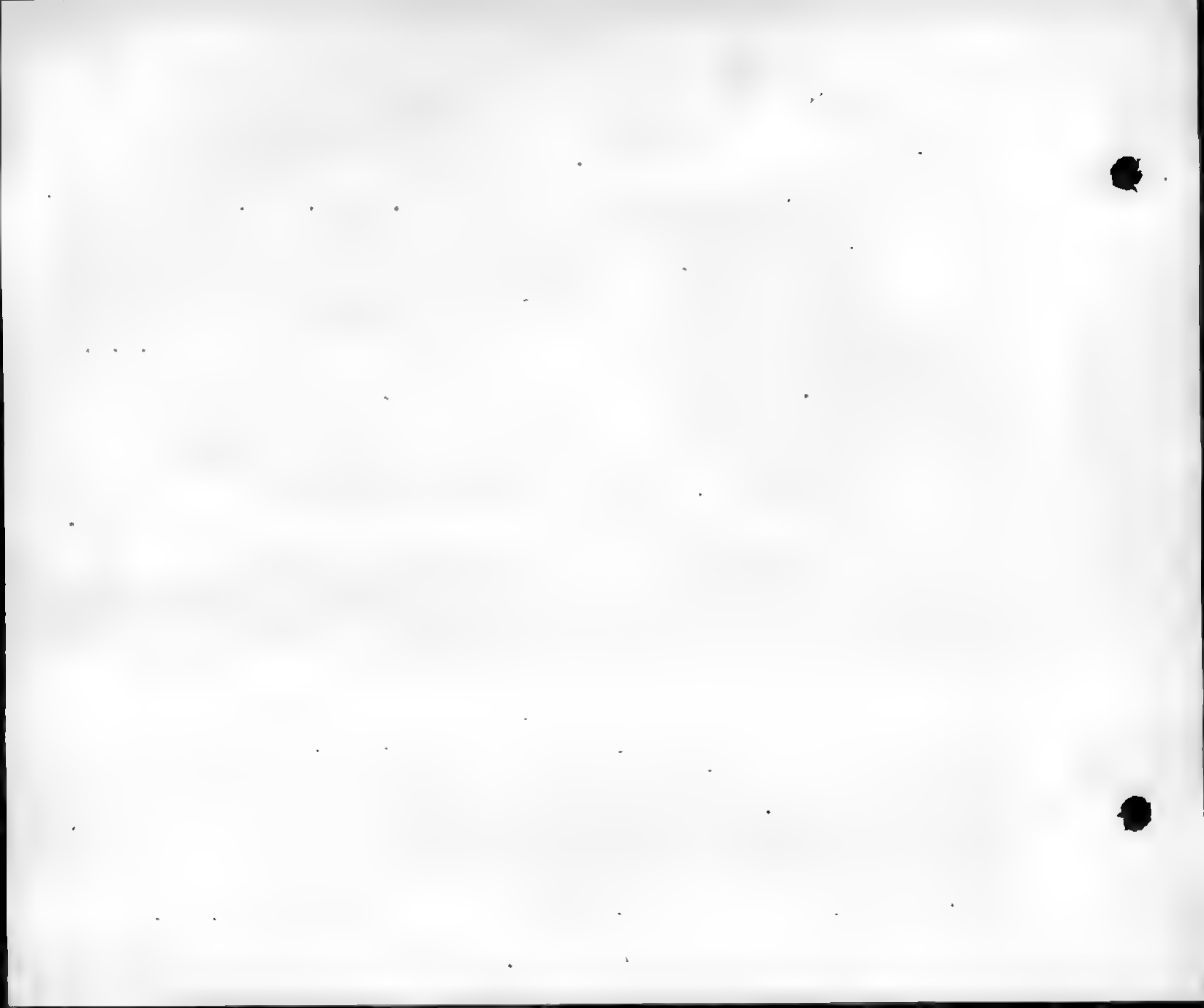
09929

CERTIFICATE OF DEATH

Reg. Dist. No.

09892

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4 c. LENGTH OF STAY IN 1b 35 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home				2. USUAL RESIDENCE (Where deceased lived. If institutor on Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4 d. STREET ADDRESS 303 W. Penn. Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Richard Nicholas Britton				4. DATE OF DEATH Month Day Year 9-12-59 19			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-12-1869	
9. AGE (In years last birthday) 90 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) superintendent				10b. KIND OF BUSINESS OR INDUSTRY cloth mill		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Richard M. Britton				14. MOTHER'S MAIDEN NAME Mary Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		INFORMANT Miss Sheldon Frantz		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED ARTERIOCLEROSIS 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) FRacture neck of right femur - JAN 3, 1959							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) FELL DOWN STAIRS AT HOME					
20c. TIME OF INJURY Hour a.m. 7 p.m. 13 Day 3 Year 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) TOWSON 4 MD.	
21. I certify that I attended the deceased from JAN 3 , 19 59 , to SEPT 12 , 19 59 , that I last saw the deceased alive on SEPT 7 , 19 59 , and that death occurred at 7:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 17 W. PENNA. AVE. BAL. DATE SIGNED 9/14/59 ACTUAL SIGNATURE T. C. Siwinski M.D. PHYSICIAN'S NAME (Type) T. C. SIWINSKI TOWSON 4 MD							
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 9-16-59		22c. NAME OF CEMETERY OR CREMATORY Poplar Grove		22d. LOCATION (City, town, or county) (State) Cockeysville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.				24a. REC'D BY REGISTRAR DATE SEP 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



09930

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admittance) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Times</u>		d. STREET ADDRESS <u>4205 Fords Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Benjamin Brodnick</u>		4. DATE OF DEATH Month <u>9</u> Day <u>21</u> Year <u>1959</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH
9. AGE (In years last birthday) <u>63</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Block maker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Louis Brodnick</u>		14. MOTHER'S MAIDEN NAME <u>Zippa</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Elyabeth Brodnick - Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Disorganization</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>Generalized atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>103 days</u> <u>103 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-15-1959</u> to <u>9-21-1959</u> , that I last saw the deceased alive on <u>9-21-1959</u> , and that death occurred at <u>11:10 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>		ADDRESS (Street, city or town, state) <u>MD 6205 Frederick Ave.</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		DATE SIGNED <u>9-22-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-22-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Carmel</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Davis Inc</u>		ADDRESS <u>2100 Eutaw Pl</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur L. King</u>	
DATE <u>SEP 22 '59</u>			



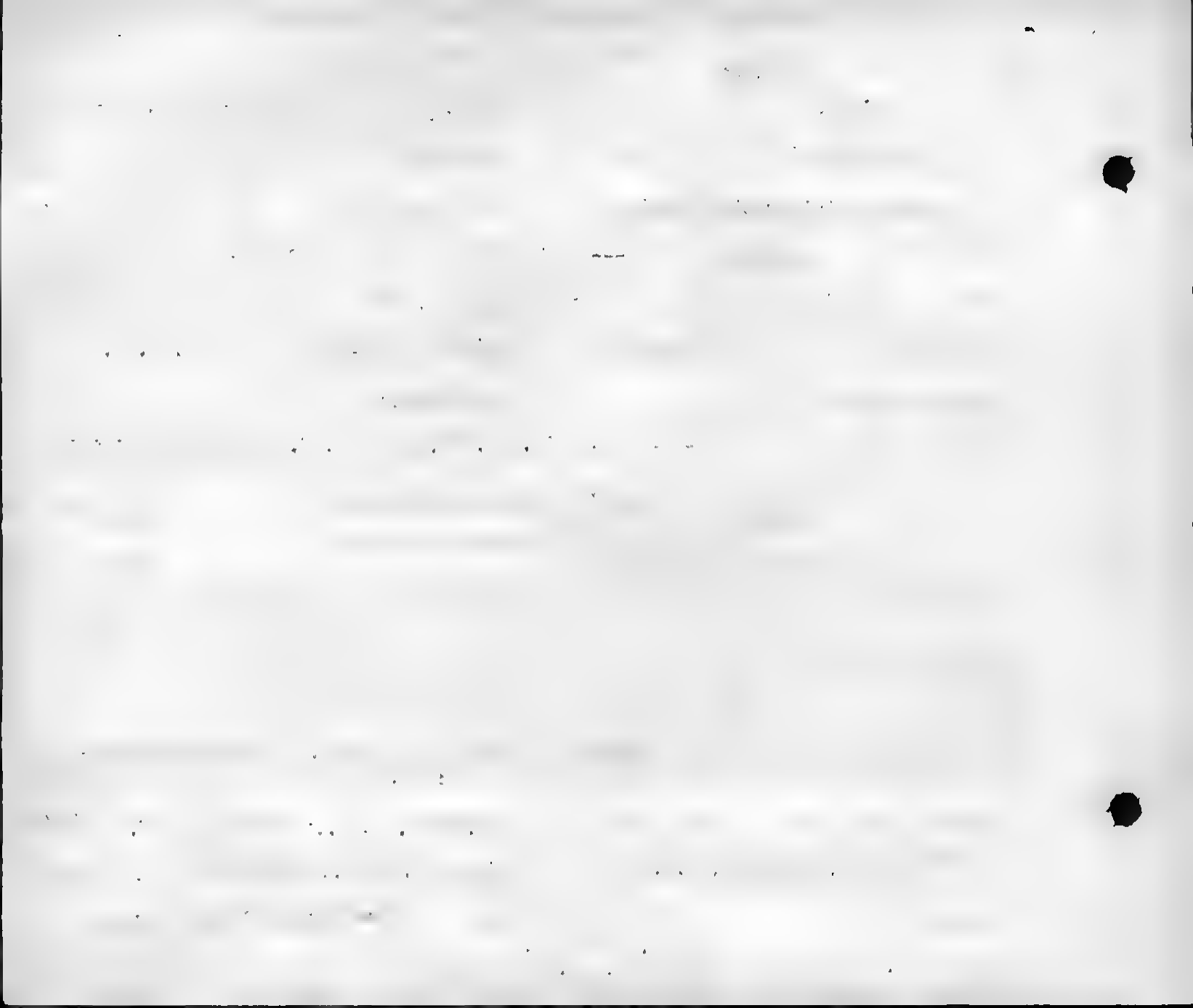
09931
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 103 Norman Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle --- Last BROWN		4. DATE OF DEATH Month September Day 1 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH November 6, 1887
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Charles Brown		14. MOTHER'S MAIDEN NAME Mary Wilhelm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 218-09-6402-	
17. INFORMANT Clin. Rec. VAH, Balto 18, Md. Fort Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOCORONARY HEART DISEASE WITH ACUTE CONGESTIVE FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE AND CHRONIC CHOLECYSTITIS WITH CHOLELITHIASIS (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I attended the deceased from August 5, 1959 , to September 1, 1959 and that death occurred at 7:45 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTO. 18, MD., FORT HOWARD DIV. 9/2/59			
ACTUAL SIGNATURE John W. Crawford M.D.		DATE SIGNED 9/2/59	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH, BALTO. 18, MD., FORT HOWARD DIV. 9/2/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-5-59	22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	22d. LOCATION (City, town, or county) (State) Anne Arundel County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. Stevens 1501 E. Fort Ave. Baltimore, Md.		24a. REC'D BY REGISTRAR DATE SEP 11 '59	24b. REGISTRAR'S SIGNATURE Charles L. Stevens

(Charles F. Diehl Successor)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

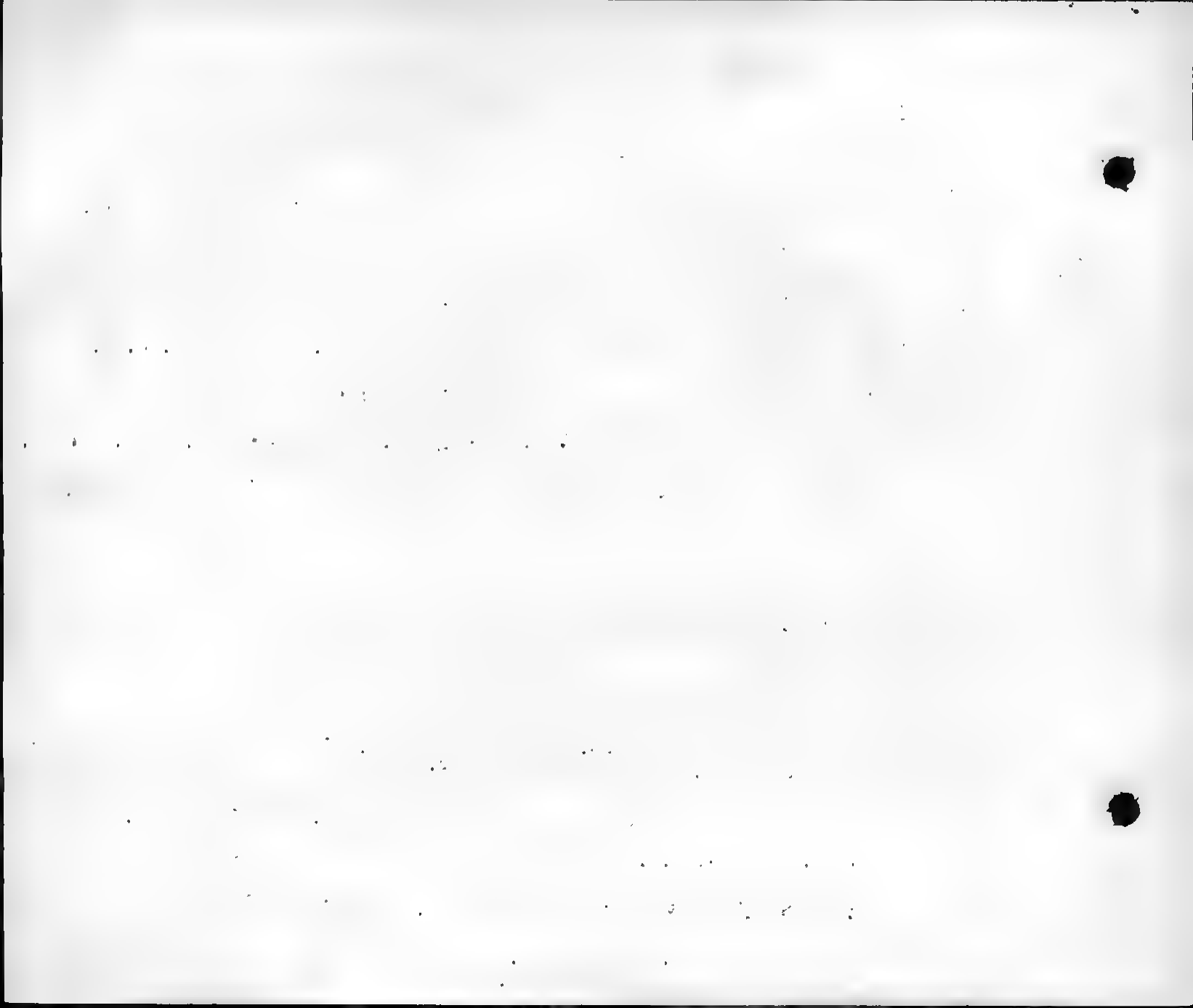
CERTIFICATE OF DEATH

Reg. Dist. No.

09895

09932

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1018 McDonnell Street (5) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JERRY Middle --- Last BRYANT				4. DATE OF DEATH Month September Day 20 Year 19 59			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1886	9. AGE (In years last birthday) 73 yrs	10. FINDER 1 YEAR Months 73 Days 73 Hours 73 Min.	11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10b. KIND OF BUSINESS OR INDUSTRY Shipping		11. BIRTHPLACE (State or foreign country) Grassy Creek, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jesse Bryant				14. MOTHER'S MAIDEN NAME Phoebe MN: Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown		INFORMANT Address VAH, Balto 18, Md. Fort Howard Div. Clin. Records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 531X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. VA 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 17 , 19 59 , to Sept. 20 , 19 59 , and that death occurred at 8:00P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTO 18 MD, FORT HOWARD DIV. 9/21/59							
ACTUAL SIGNATURE David A. Oursler		M.D. DAVID A. OURSLER, M.D.					
PHYSICIAN'S NAME (Type) DAVID A. OURSLER, M.D.							
22a. BURIAL, CREMAT. OR REMOVAL (Specify) Burial		22b. DATE THEREOF 9-24-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Elliott Funeral Home 1129 N. Caroline St. Balto. Md.				24a. REC'D BY REGISTRAR DATE SEP 24 '59		24b. REGISTRAR'S SIGNATURE Arthur B. Knecht	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09933

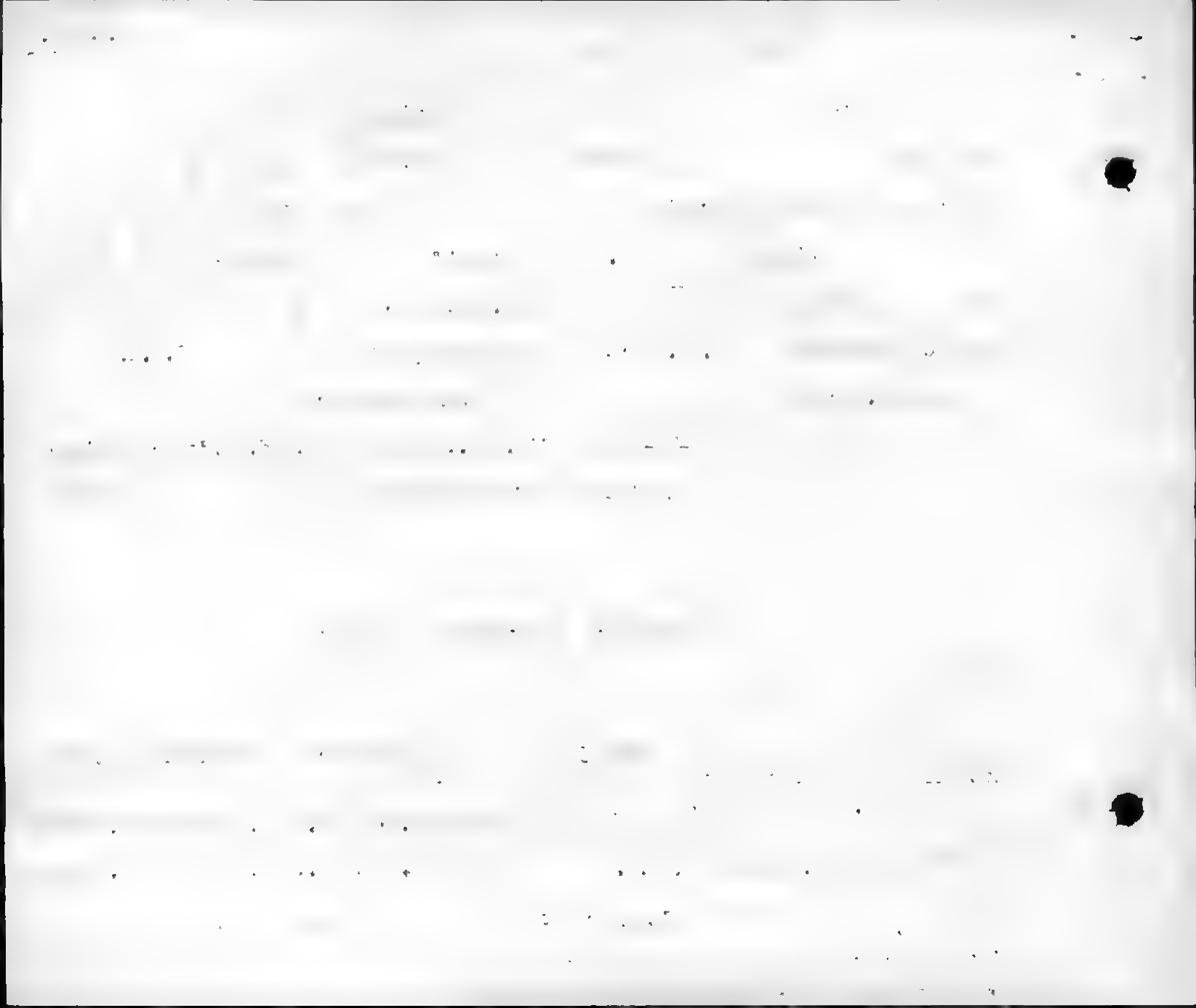
CERTIFICATE OF DEATH

09896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 95 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 1149 Sanford Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle B. Last BRYANT		4. DATE OF DEATH Month September Day 6 Year 1959	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1895
9 AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vehicle Dispatcher		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	
11. BIRTHPLACE (State or foreign country) Nokomis, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph R. Bryant		14. MOTHER'S MAIDEN NAME Marie Burroughs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 215-18-9160	
17. INFORMANT Clin. Rec., VAH Balto 18, Md. Ft. Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LEFT SIDE OF NECK 199.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HEMORRHAGE OF CARCINOMATOSIS SITE		INTERVAL BETWEEN ONSET AND DEATH 9 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 3 , 19 59 , to September 6 , 19 59 , and that death occurred at 7:45 A.M. from the causes and on the date stated above Walter C. Goldstein, M.D. ADDRESS (Street, city or town, state) DATE SIGNED 9/6/59			
ACTUAL SIGNATURE Walter C. Goldstein, M.D.		M.D. VAH Balto. 18, Md., Ft. Howard Div. 9/6/59	
PHYSICIAN'S NAME (Type) WALTER C. GOLDSTEIN, M.D.		VAH Balto. 18, Md., Ft. Howard Div. 9/6/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook - Blight, Inc. 6009 Harford Rd.		24a. REC'D BY REGISTRAR DATE SEP 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Kline			

WM. COOK-BLIGHT, INC. 6009 HARFORD RD BALTO 14 MD



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

VS. A15ME
EM 7/59

FOR STATE
HEALTH DEPT.

CENTRAL STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

195897

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if last in residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7700 York Road		d. STREET ADDRESS 7700 York Road	
3. NAME OF DECEASED (Type or print) Ethel Marie Buckley		4. DATE OF DEATH Month 9 Day 27 Year 1959	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 1, 1909	
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months 4 Days 26 Hours 1 Min 0	
11. AGE (In years last birthday) 48 yrs.		12. IF UNDER 24 HRS. Hours 1 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant- Psycho.		10b. KIND OF BUSINESS OR INDUSTRY Sheppard-Pratt Hosp. S. Carolina	
11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James A. Norton, Sr.		14. MOTHER'S MAIDEN NAME Alice Edens	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 243-22-3392	
17. INFORMANT Woodrow Wilson Buckley, Towson, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE a. Arteriosclerotic heart disease b. 4 - U.C. c. 4 - U.C. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 4 - U.C.		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County)	
20g. (State)		20h. (Country)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher		M.D.	
EXAMINER'S NAME (Type) Russell S. Fisher		DATE SIGNED 9/28/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal/Burial		22b. DATE THEREOF Sept. 27, 1959	
22c. NAME OF CEMETERY OR CREMATORY Salemberg Cemetery		22d. LOCATION (City, town, or country) Salemberg, North Carolina	
23. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR SEP 30 '59		24b. REGISTRAR'S SIGNATURE Charles S. Fisher	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

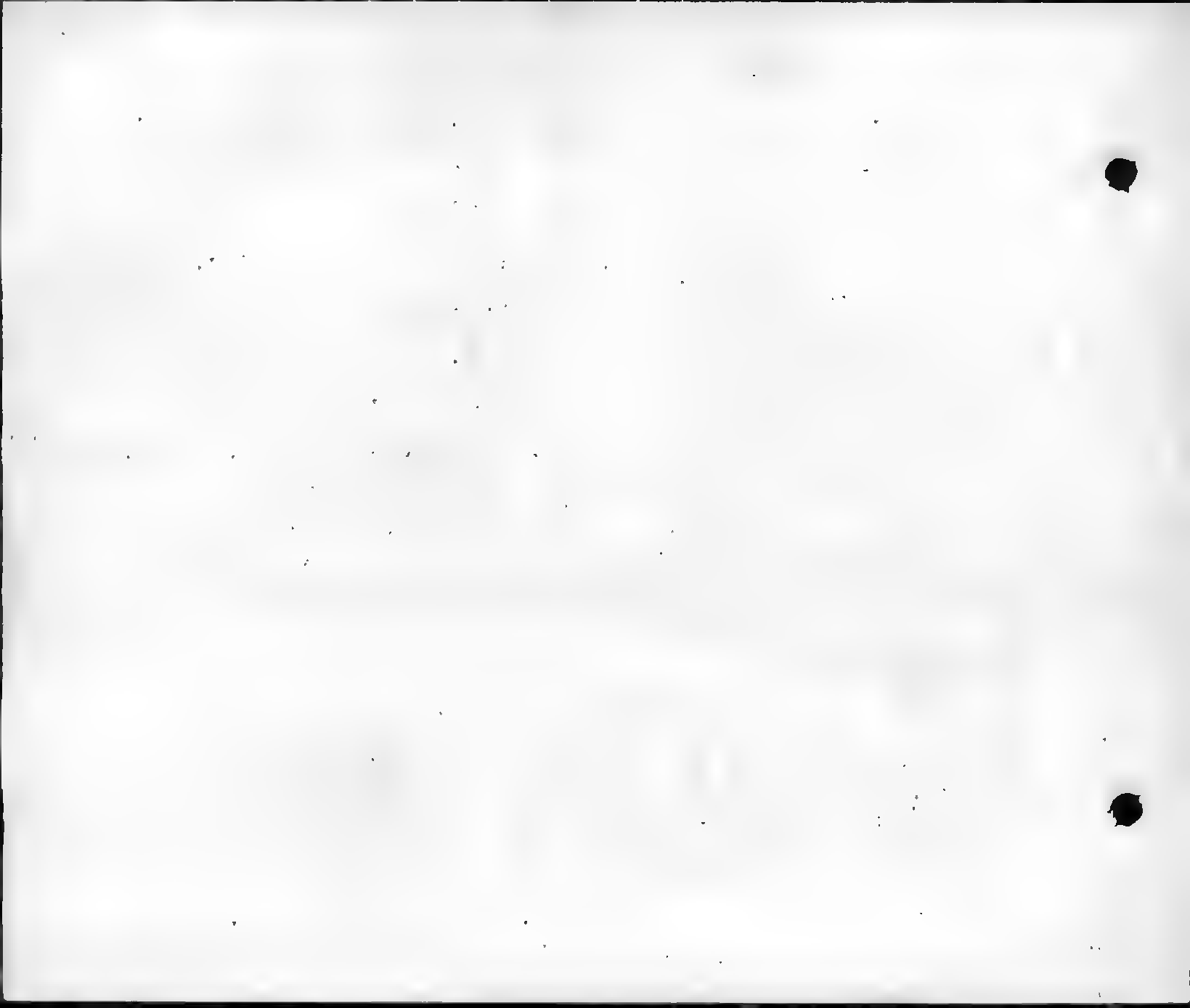
09935

CERTIFICATE OF DEATH

09898

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glencoe</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Glencoe</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glen Oaks</u>				/d. STREET ADDRESS <u>Glen Oaks</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELLEN</u> Middle <u>W.</u> Last <u>BUFFINGTON</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>18</u> Year <u>19 59</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 8, 1901</u>	
9. AGE (In years last birthday) <u>58</u> yrs		10. UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>			
13. FATHER'S NAME <u>John Watson</u>				14. MOTHER'S MAIDEN NAME <u>Eva Matthews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>Mr. Louis Buffington</u>				Address <u>105 E. 54th St. New York #22, N.Y.</u>			
18. CAUSE OF DEATH [Enter only one cause, according to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO <u>10 yrs</u> (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>59</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>Sept 15, 1959</u> to <u>Sept 18, 1959</u> that I last saw the deceased alive on <u>Sept 15, 1959</u> and that death occurred at <u>11:00 AM</u> from the causes and on the date stated above. ADDRESS (Street city or town state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>John R. Davis</u>				M.D. <u> </u>			
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Lickner & Sons</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09899

Reg. Dist. No.

09895

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> d. STREET ADDRESS <u>7141 Holabird Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Alex Buck Bullard</u> First Middle Last				4. DATE OF DEATH <u>Sept 28</u> / 59 Month Day Year									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 22 1910</u>		9. AGE (In years last birthday) <u>48</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lunch Wagon Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>North Carolina</u>				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Lonnie Bullard</u>						14. MOTHER'S MAIDEN NAME <u>Azzie Willowghby</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mrs Gwen Bullard</u> <u>7141 Holabird Ave</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u> (b) _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <u>M. B. Davis</u> M.D. EXAMINER'S NAME (Type) <u>M. B. DAVIS MD</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>remal</u>				22b. DATE THEREOF <u>Sept 29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Brook Cem</u>				22d. LOCATION (City, town, or county) (State) <u>Lumbertown North Carolina</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 2112 Dundalk Ave</u> ADDRESS						24a. REC'D BY REGISTRAR <u>OCT 2 '59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hawk</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09900

09936

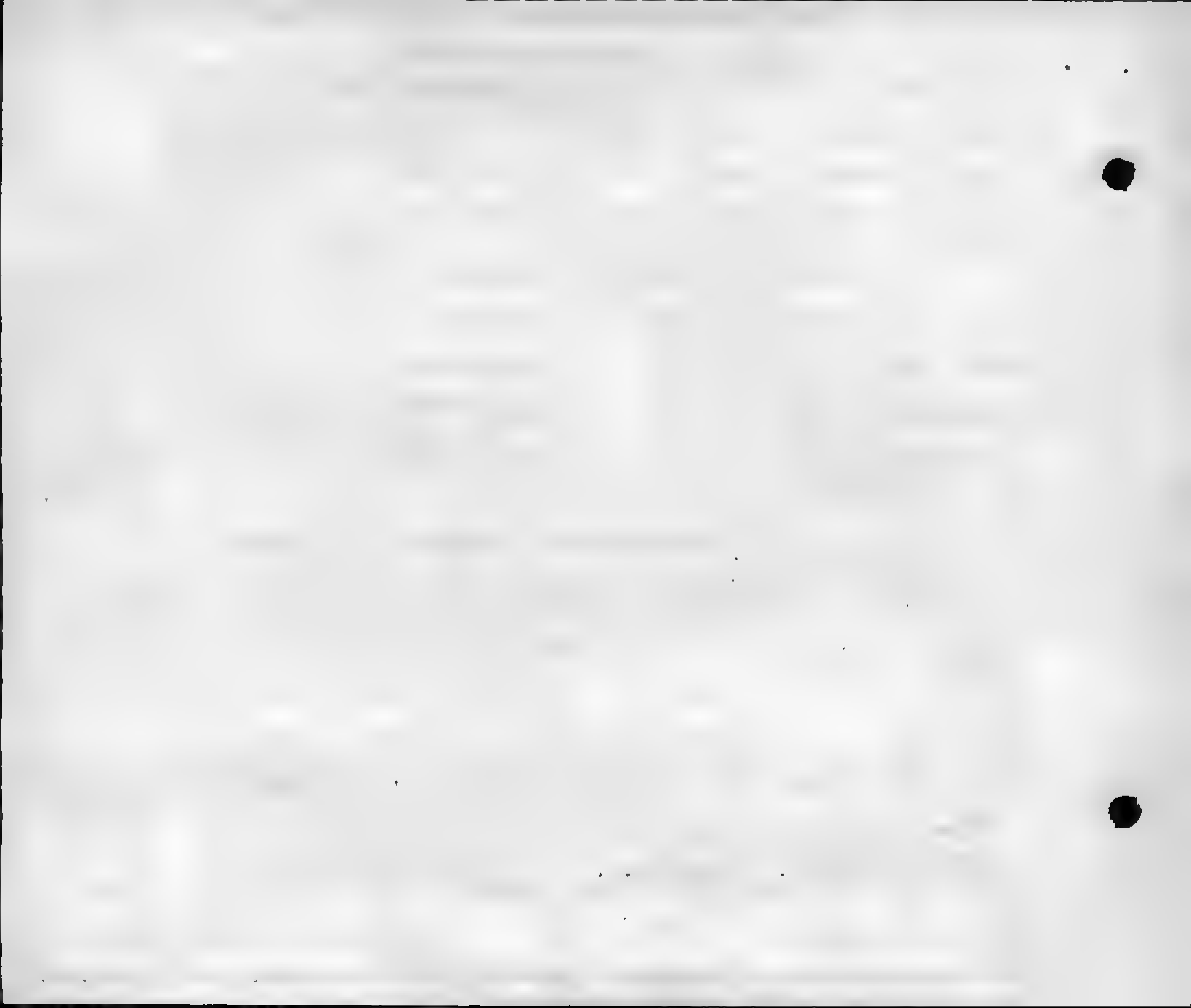
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>		c. LENGTH OF STAY IN TB <u>2 1/2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>POWERS AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MATILDA M. BURTON</u>		4. DATE OF DEATH Month Day Year <u>9 7 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 5, 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>JOSEPH SMITH</u>		14. MOTHER'S MAIDEN NAME <u>LOUISA WILLIAMS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>JOSEPH BURTON - POWERS AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic CardioVascular Disease</u> and (c) <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 17</u> , 19 <u>59</u> to <u>September 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>September 7</u> , 19 <u>59</u> , and that death occurred at <u>9 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>48 Main Street</u> <u>9/8/59</u>			
ACTUAL SIGNATURE <u>Martin E. Strobel</u>		M.D. <u>Reisterstown, Maryland</u>	
NAME (Type) <u>Martin E. Strobel M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>9/11/59</u>	<u>Wesley Grove</u>	<u>Boring Mts. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. C. Klatzman</u>		ADDRESS <u>1701 W. Collob</u> <u>Balt., Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09937

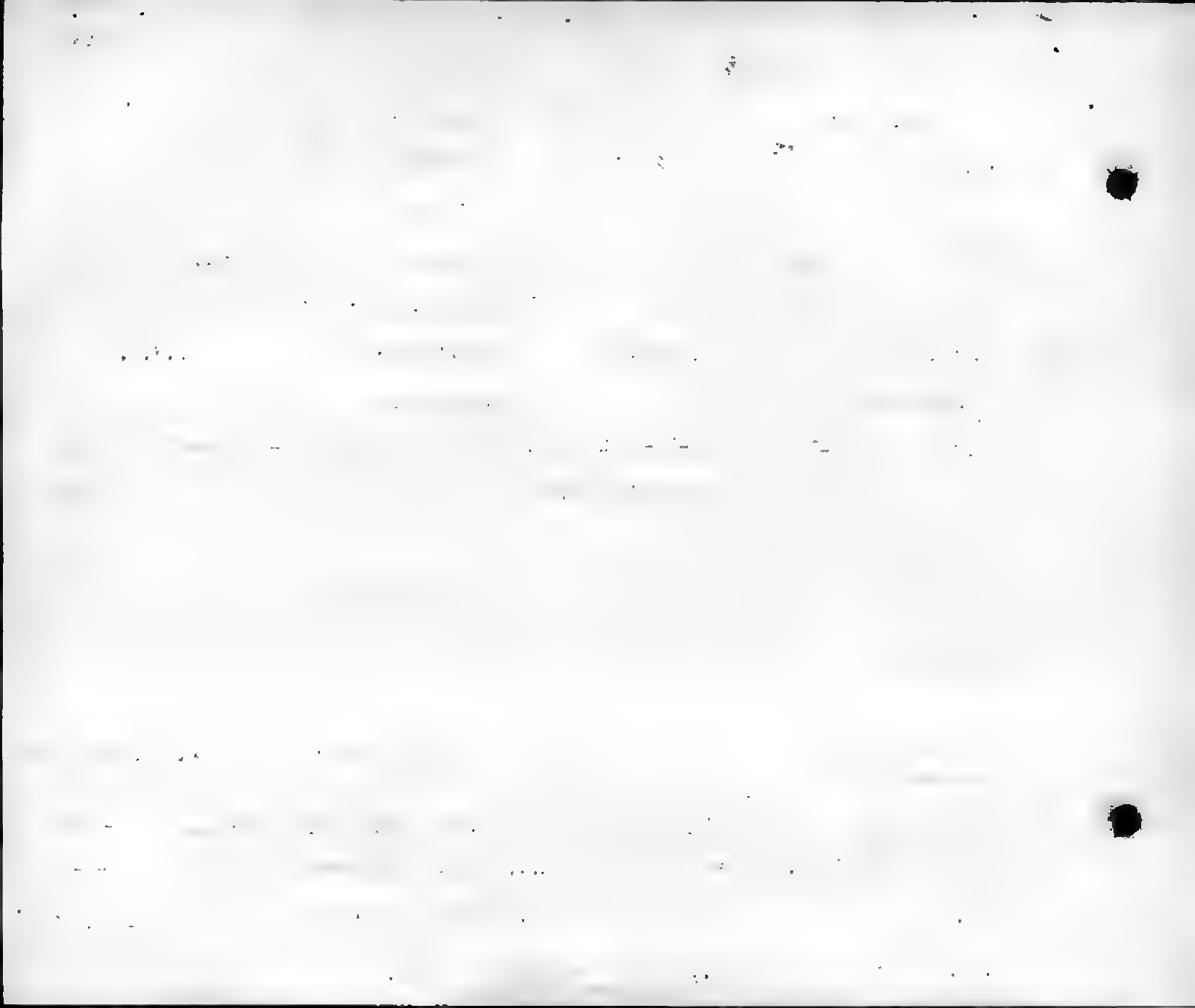
09991

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 32 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TILGHMAN ISLAND	
3. NAME OF DECEASED (Type or print) First FRED Middle E Last BYERS		4. DATE OF DEATH Month SEPTEMBER Day 6 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 19, 1896
9. AGE (In years lost birthday) 62 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY UNEMPLOYED	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARION BYERS		14. MOTHER'S MAIDEN NAME ANNA HUNKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO 220-32-0042	
17. ADDRESS CLIN REC VAH BALTIMORE MD-FORT HOWARD DIVISION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HODGKINS DISEASE X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from August 5 , 19 59 , to September 6 , 19 59 , that VA was the attending physician and that death occurred at 11:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Clovis M. Snyder M.D.		ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 9-7-59	
PHYSICIAN'S NAME (Type) Clovis M. Snyder		M.D. VAH, Fort Howard, Maryland 9-7-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-10-59	22c. NAME OF CEMETERY OR CREMATORY WESTMORELAND CO. MEMORIAL PARK GREENBURG, WESTMORELAND CO.	22d. LOCATION (City, town, or county) (State) PENNA.
23. FUNERAL DIRECTOR'S SIGNATURE Mr. J. Tiekner & Sons, Inc., North & Pennsylvania Aves. Baltimore, Maryland		24a. REC'D BY REGISTRAR DATE SEP 8 59 24b. REGISTRAR'S SIGNATURE C. J. & Sons	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.

CERTIFICATE OF DEATH

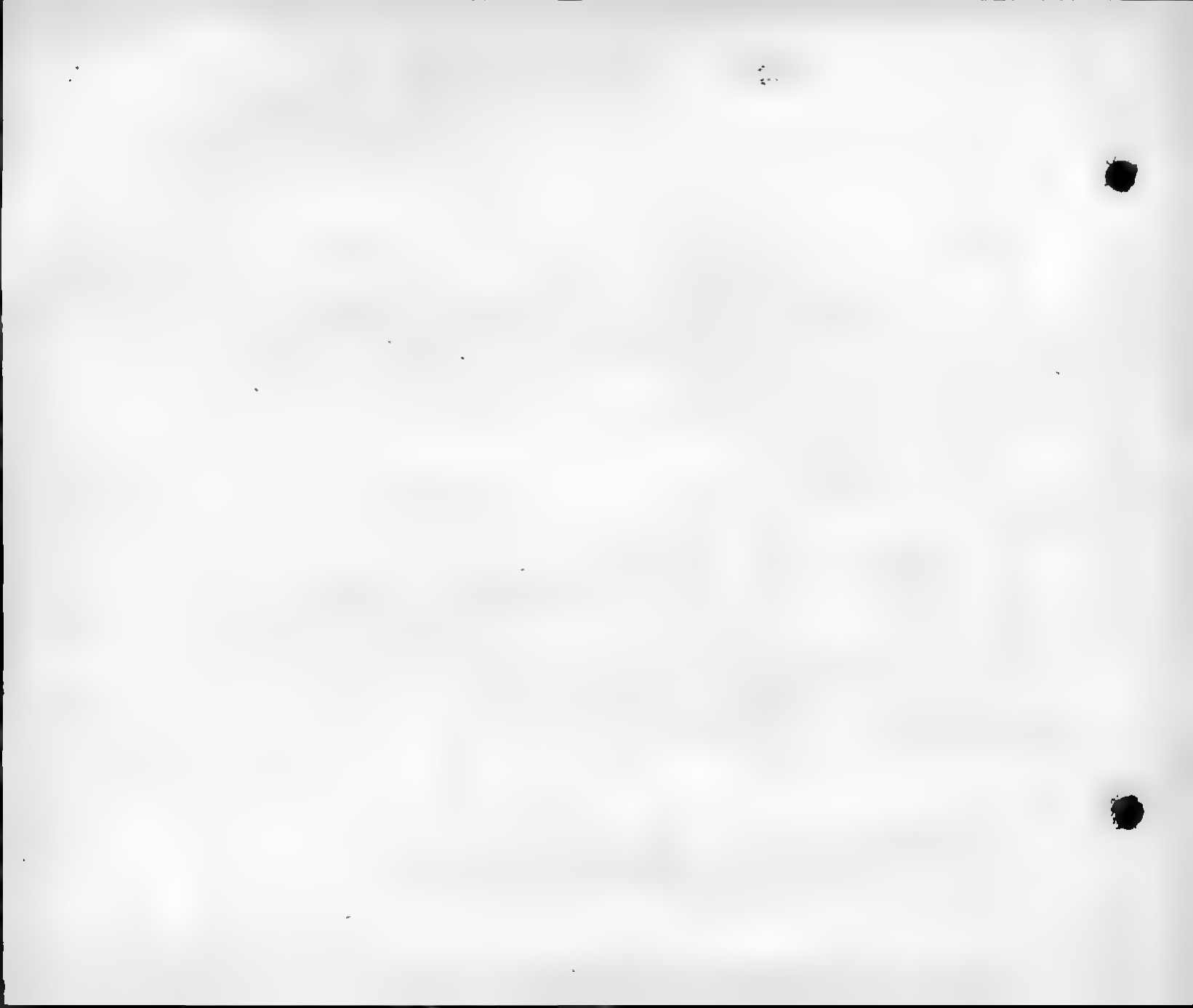
05902

09903

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> c. LENGTH OF STAY IN 1b <u>8 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4308 Wilkens Ave</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Arbutus</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> d. STREET ADDRESS <u>4308 Wilkens Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Stephen P. Cadden Sr.</u> First Middle Last		4. DATE OF DEATH Month <u>9</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1871</u> 9. AGE (In years last birthday) <u>87</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Belt School Board, Barton Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick Cadden</u>		14. MOTHER'S MAIDEN NAME <u>Ann Stanton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Dr. John J. Cadden</u> Address <u>Home</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FIBRILLATION</u> DUE TO <u>MYOCARDITIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSION</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>FEB 1</u> , 19 <u>51</u> , to <u>SEPT 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>SEPT 23</u> , 19 <u>59</u> , and that death occurred at <u>7 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Daniel S. Shanahan M.D.</u>		ADDRESS (Street, city or town, state) <u>1011 N. CHAPMAN ST.</u>	
PHYSICIAN'S NAME (Type) <u>DANIEL S. SHANAHAN M.D.</u>		DATE SIGNED <u>9/24/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>9/26/59</u>	<u>Landon Park Cem.</u>	<u>3801 Frederick Ave</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Gowanlock</u>		24a. REC'D BY REGISTRAR <u>SEP 25 59</u>	
ADDRESS <u>4308 Wilkens Ave</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Knecht</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



09938

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL or give nearest town) Lutherville				c. LENGTH OF STAY IN 1b Life			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville, Maryland				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 202 1/2 Lincoln Ave.			
d. STREET ADDRESS 202 1/2 Lincoln Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charlotte Middle Cheatham Last				4. DATE OF DEATH Month September Day 28 Year 19 59			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 13, 1872	
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS. Months Days Hours Min		12. IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Monkton, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.				13. FATHER'S NAME John W. Harris			
14. MOTHER'S MAIDEN NAME Julia Harris				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address Mrs. Anna Jackson 202 Lincoln Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Sigmoid 1533 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardio Vascular Renal & Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 3 Mths							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/4 , 19 59 , to 9/28 , 19 59 , that I last saw the deceased alive on 9/27 , 19 59 , and that death occurred at 9:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 19 W. Seminary Ave., Lutherville. DATE SIGNED 9/28/59							
ACTUAL SIGNATURE Bennett A. Steen M.D. 19 W. Seminary Ave., Lutherville. DATE SIGNED 9/28/59							
PHYSICIAN'S NAME (Type) Bennett A. Steen							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Sept. 30, 1959		St. Luke Church Cemetery		Hereford, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William A. Jackson Funeral Home Inc. 916 Penna Ave.				24a. REC'D BY REGISTRAR DATE SEP 30 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kears	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 1
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

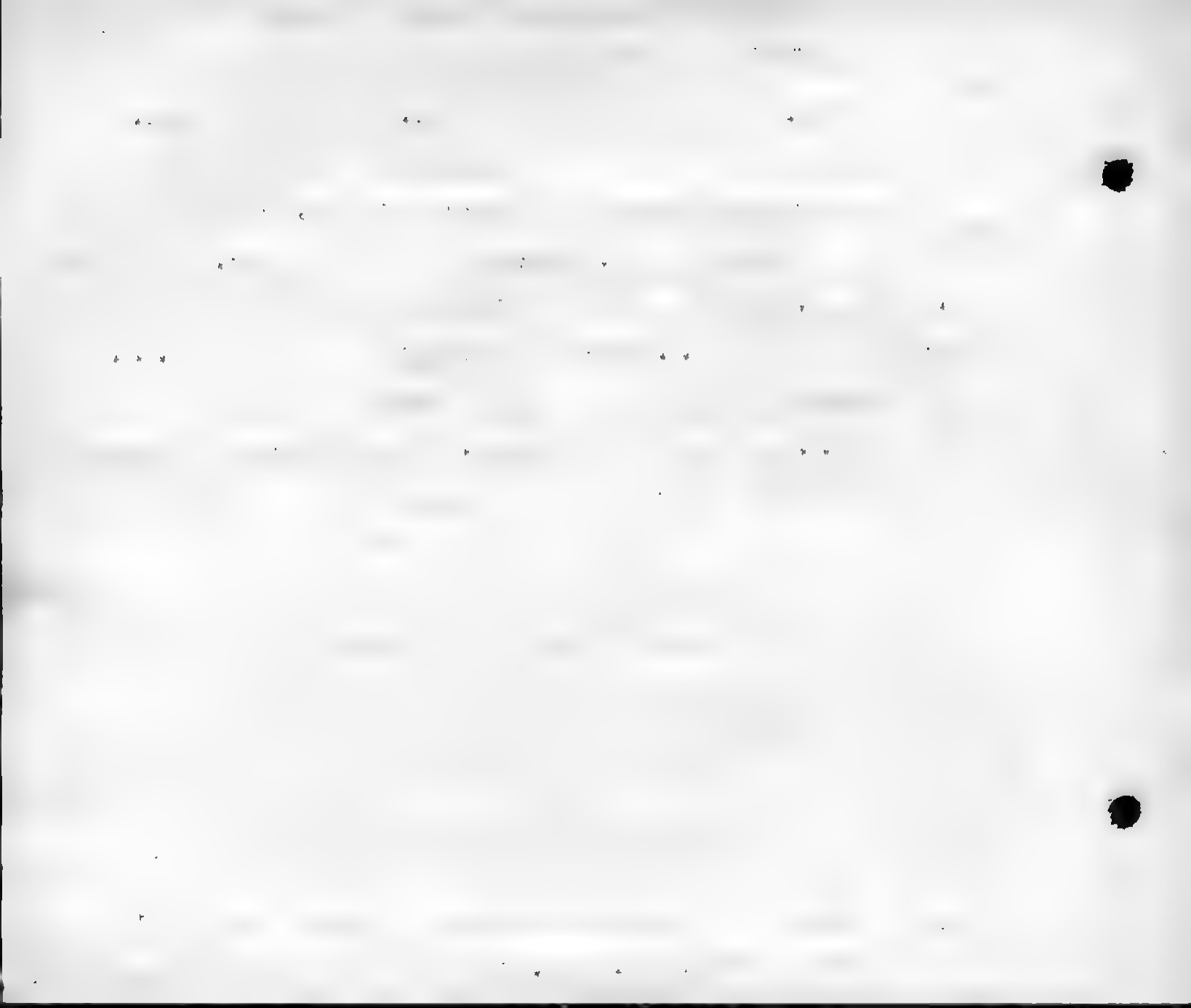
09904

09939

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) b. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Edmar Orchid Road Box 180		d. STREET ADDRESS Edmar Orchid Road, Box 180	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joshua Middle G. Last Chenoweth		4. DATE OF DEATH Month Sept. Day 26 Year 19 59	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> Never married Divorced	8. DATE OF BIRTH 7/19/99
9. AGE (In years last birthday) yrs. 60		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.I		16. SOCIAL SECURITY NO. None	
17. INFORMANT Gladys I. Chenoweth Edmar Orchid Road Box 180		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastatic carcinoma - lung DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 26, 19 59 to Sept. 26, 19 59 , that I last saw the deceased alive on Sept. 26, 19 59 , and that death occurred at 11 P. M, from the causes and on the date stated above ADDRESS (Street, city or town, state) 8627 Liberty Rd. Randallstown, Md. DATE SIGNED			
ACTUAL SIGNATURE M. D. Elin M.D.			
PHYSICIAN'S NAME (Type) M. D. Elin, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/59	
22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge Memorial		22d. LOCATION (City, town, or county) (State) Dorsey Howard Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PAUL CHENOWETH		24a. REC'D BY REGISTRAR SEP 28 '59	
ADDRESS 3617 Chestnut Av. Balto. 11		24b. REGISTRAR'S SIGNATURE John S. King	



CERTIFICATE OF DEATH

Reg. Dist. No.

09940

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 6yr3dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 15			
f. STREET ADDRESS 2830 Park Avenue				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GERMAINE D. CIRIGLIANO (Also Melvin)				4. DATE OF DEATH Month Day Year September 25 19 59			
5 SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1901		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) France		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Demerest				14. MOTHER'S MAIDEN NAME Beatha Dutoor Germaine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure							
+20.1 DUE TO (b) Myocardial infarctions							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Coronary sclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1, 19 58 , to Sept. 25, 19 59 , that I last saw the deceased alive on Sept. 25, 19 59 , and that death occurred at 12:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachsler				ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 9-25-59			
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/59		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner + Sons				24a. REC'D BY REGISTRAR DATE SEP 28 59		24b. REGISTRAR'S SIGNATURE Richard B. Pomeroy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.



CERTIFICATE OF DEATH

09906

Reg. Dist. No.

09941

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
c. LENGTH OF STAY IN 1b <u>14 yrs.</u>		d. STREET ADDRESS <u>645 Lexington Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>645 Lexington Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARIE - CECILIA - CITRANO</u>		4. DATE OF DEATH <u>Sept. 30 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilmington Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alfred Boulay</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Kelly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>44-1550</u>	
17. INFORMANT <u>William P. Burke</u>		Address <u>145 Lexington Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Rupture</u> 451X DUE TO (b) <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture compression, dorsal vertebrae</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Fall, August 13, 1959, in home</u>			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>Aug 13 1959</u>	
20d. INJURY OCCURRED <u>While of work</u> <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Baltimore 28</u>		(County) _____ (State) <u>MD.</u>	
21. I certify that I attended the deceased from <u>Dec 1957</u> , to <u>30 Sept 1959</u> , that I last saw the deceased alive on <u>29 Sept 1959</u> , and that death occurred at <u>7:35 PM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>James J. Nolan</u>		DATE SIGNED <u>9/30/59</u>	
PHYSICIAN'S NAME (Type) <u>JAMES J. NOLAN</u>		<u>BALTIMORE 29 MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 3 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore City</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Gierke</u>		ADDRESS <u>5311 Edmondson Ave</u>	
24a. REC'D BY REGISTRAR <u>Oct 2 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09907

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Towson, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Woodbrook Lane-Towson, Md.		d. STREET ADDRESS 1738 Druid Hill Avenue	
3. NAME OF DECEASED (Type or print) First Annie Middle E. Last Clark		4. DATE OF DEATH Month Sept. Day 28, Year 1959	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1900
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Pvt. Family	
11. BIRTHPLACE (State or foreign country) Maiseville, S. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Newton		14. MOTHER'S MAIDEN NAME Rebecca Clevon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-30-6845	
17. INFORMANT Address Mr. Jake Newton-660 Fairmount Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>80 years</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles F. Donnell		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 2, 1959	
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home-1631 Druid Hill Ave		24a. REC'D BY REGISTRAR DATE OCT 6 1959	
24b. REGISTRAR'S SIGNATURE Charles F. Donnell			

STAL OFFICE BLDGS. BALTO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

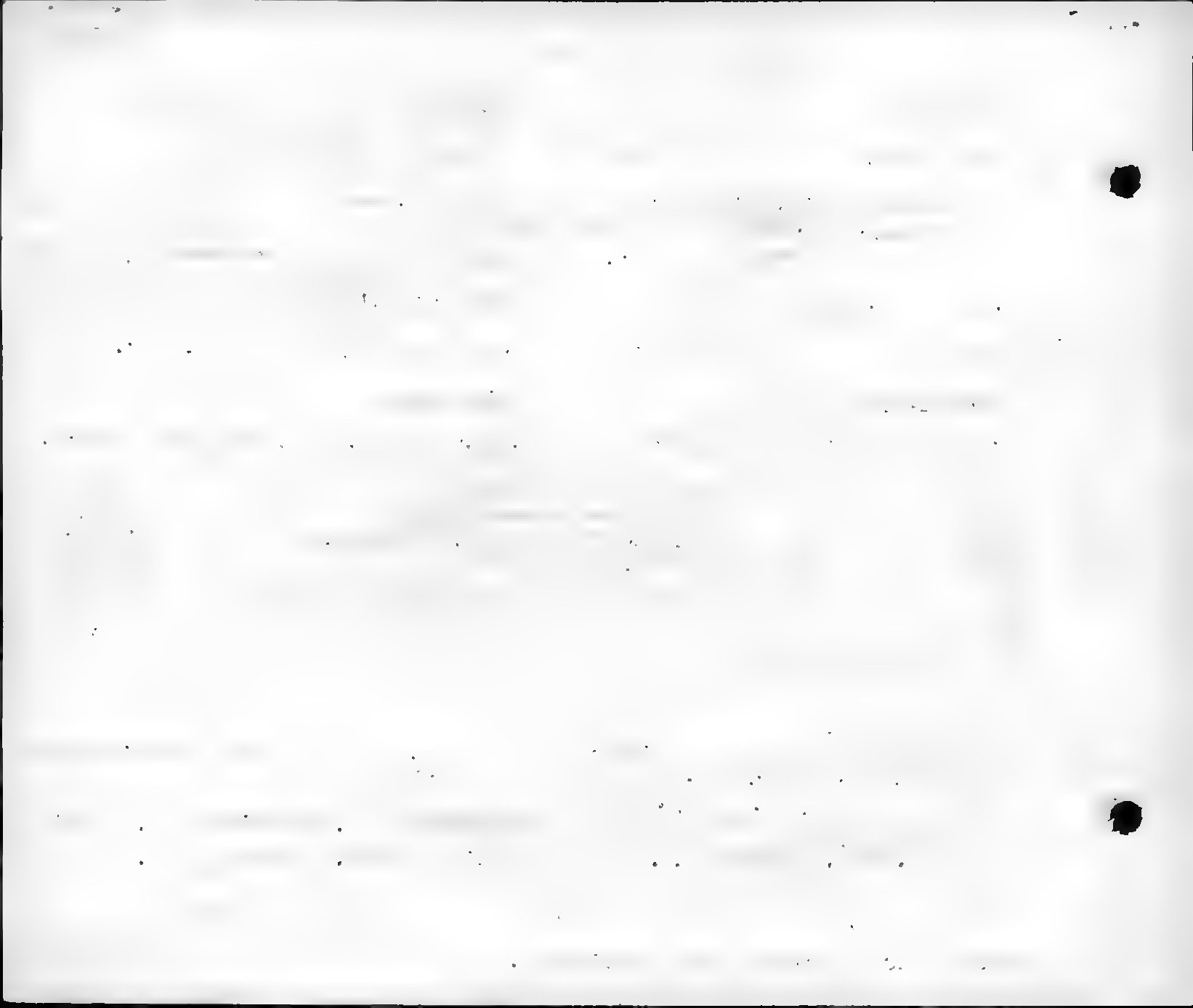
CERTIFICATE OF DEATH

Reg. Dist. No.

09943

09908

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 118 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 2 Pine Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Served as BRICE (NMT) COLEMAN) (Type or print) BRICE K. COLEMAN		4. DATE OF DEATH Month September Day 3 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (1896) September 15, '96 AGE (In years last birthday) 62 IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Can Maker		10b. KIND OF BUSINESS OR INDUSTRY Can Company	11. BIRTHPLACE (State or foreign country) Cambridge, Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Eam Coleman		14. MOTHER'S MAIDEN NAME Eliza Sampson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO 211-07-7035 INFORMANT Glin. Rec. VAH, Balto. 18, Md. Fort Howard Division Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any which gave rise to immediate cause (a), stating the under-lying cause last: DIVERTICULITIS COLON WITH OBSTRUCTION CARCINOMA, KIDNEY, LEFT METASTATIC CARCINOMA LIVER AND LEFT ADRENAL.			INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 8 19 59 , to September 3, 1959 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTO 18, MD. FORT HOWARD DIV. 9/3/59			
ACTUAL SIGNATURE John W. Crawford		PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. VAH, BALTO 18, MD. FORT HOWARD DIV.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/6/1959	22c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery	22d. LOCATION (City, town, or county) (State) Cambridge, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Herbert St. Clair Funeral Home, Cambridge, Md.		24a. REC'D BY REGISTRAR DATE SEP 9 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Howard



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LUTHERVILLE</u> c. LENGTH OF STAY IN TB <u>1 1/2 HRS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1613 DIVISION ST</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 WEST ROAD</u> d. STREET ADDRESS <u>110 W. 4, M.D.</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GRAHAM W. FIELD CRAWFORD</u>	4. DATE OF DEATH Month <u>SEP</u> Day <u>3</u> Year <u>1959</u>	5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12-10-1879</u> 9. AGE (In years, last birthday) <u>79</u> 10. IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> 11. IF UNDER 24 HRS Hours <u>11</u> Min <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOOK BINDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOOK CONSTRUCTION</u>	
11. BIRTHPLACE (State or foreign country) <u>M.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM A. CRAWFORD</u>		14. MOTHER'S MAIDEN NAME <u>AMOS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. E. W. CRAWFORD</u> Address <u>WEST RD, TOWSON, M.D.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4 PREMIA</u> <u>591X</u> DUE TO (b) <u>ACUTE NEPHROSIS</u> Conditions, if any, which gave rise to immediate cause (c) <u>—</u> (a), stating the underlying cause last.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William H. Pillsbury</u>		DATE SIGNED <u>9/13/59</u>	
EXAMINER'S NAME (Type) <u>WILLIAM H. PILLSBURY</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-6-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. JAMES EPISCOPAL</u>	22d. LOCATION (City, town, or county) (State) <u>NIGHTON - M.D.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. M. COOK-TOWSON, INC. - TOWSON, MD</u>		24a. REC'D BY REGISTRAR <u>SEP 8 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Charles E. Evans</u>	



09945

CERTIFICATE OF DEATH

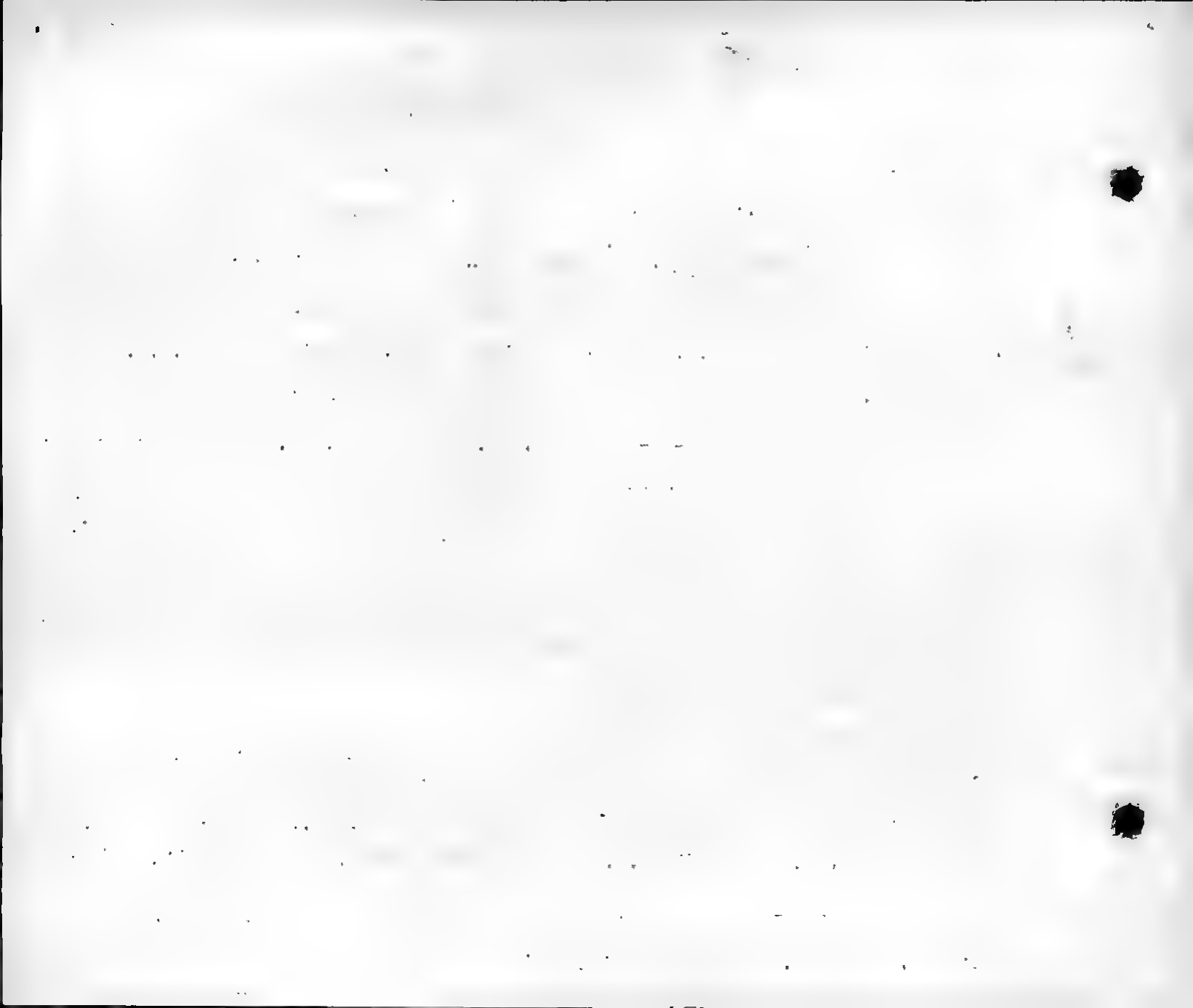
09910

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 64 Days		d. STREET ADDRESS 4705 Charlton Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Served As: First ELIAS Middle J. CUMBEST Last JAMES E. CUMBEST, SR.		4. DATE OF DEATH Month September Day 6 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/12/96
9. AGE (In years last birthday) 63 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	11. BIRTHPLACE (State or foreign country) Sales City, Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Elias J. Cumbest	
14. MOTHER'S MAIDEN NAME Marzillie Shiver		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I	
16. SOCIAL SECURITY NO. 213-01-3437		17. INFORMANT Clin. Rec. VAH, Balto 18, Md. Fort Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL ABDOMINAL CARCINOMATOSIS 154X DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost. (b) ADENOCARCINOMA OF RECTOSIGMOID DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 YEARS APPROX. 2 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 4, 1959 to September 6, 1959 , and that death occurred at 11:15 AM from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Walter C. Goldstein M.D. VAH, BALTO 18, MD., FORT HOWARD DIVISION ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) WALTER C. GOLDSTEIN, M.D. VAH, BALTO 18, MD. FORT HOWARD DIV. 9/6/59			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 9-10-59	
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Parkville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck Inc.		24a. REC'D BY REGISTRAR DATE SEP 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08911

09946

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE, <u>md</u> b. COUNTY <u>_____</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgess Forge</u>		c. LENGTH OF STAY IN It	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Mersey Villa Beltona Ave</u>		4. STREET ADDRESS <u>Hopkins Apts 5100 1/2 Bw't</u>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH F DALY</u>		4. DATE OF DEATH <u>Sept 17 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 16 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Michael Daly</u>		14. MOTHER'S MAIDEN NAME <u>Bridget Pagan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>_____</u>	
17. INFORMANT <u>John 32-1-1</u>		Address <u>_____</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arterio sclerosis</u>			<u>5 days</u>
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) <u>Generalized arteriosclerosis, severe</u>			<u>10 days</u>
DUE TO			
(c) <u>_____</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>May 30, 1946</u> to <u>Sept 17, 1959</u> , that I last saw the deceased alive on <u>Sept 8, 1959</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frederick J. Vollmer</u>		ADDRESS (Street, city or town, state) <u>600 York Rd Balto Md</u>	
PHYSICIAN'S NAME (Type) <u>FREDERICK J. VOLLMER</u>		DATE SIGNED <u>9/18/59</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>Sept 19/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Park</u>	22d. LOCATION (City, town, or county) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. Hinkle</u>		ADDRESS <u>4915 York Rd</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hinkle</u>	



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03912

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. LENGTH OF STAY IN 1b <u>20</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>210 Langley Rd</u> <u>20</u>		d. STREET ADDRESS <u>210 Langley Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph Daniel Davis</u>		DATE OF DEATH <u>Sept 16</u> 19 <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-20-1907</u>
9. AGE (in years last birthday) <u>52</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RR Construction</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Hoyd Davis</u>	
14. MOTHER'S MAIDEN NAME <u>Lottie Arnold</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO <u>233-10-7558</u>		17. INFORMANT <u>Ida Davis</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>6 hours</u> (c) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Jack C. Collins</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Jack C. Collins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9-17-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-19-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brothers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Flintstone Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Christine Brydzinski</u> ADDRESS <u>1407 Eastern Ave</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 18 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. K...</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09913

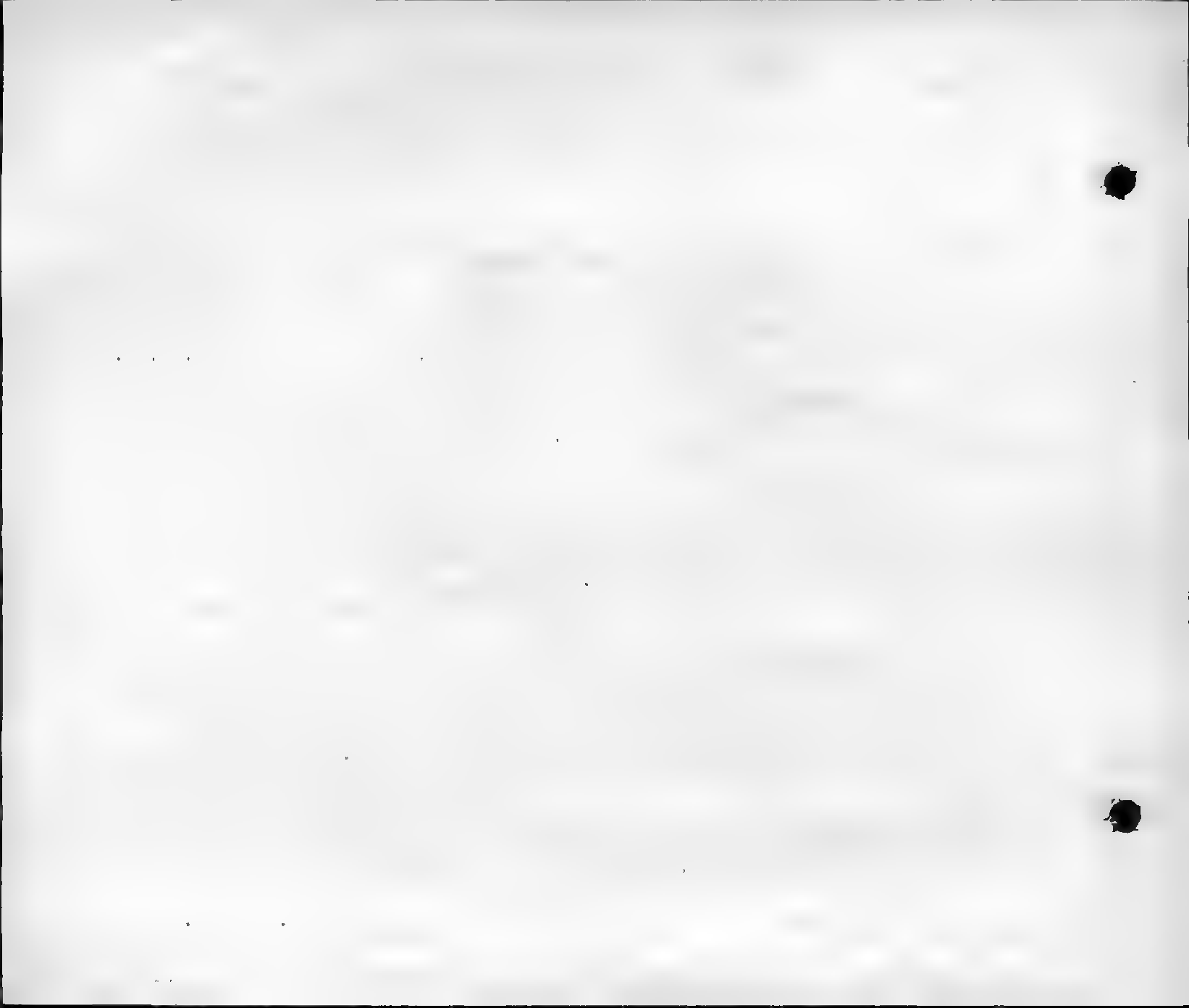
09948

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr7mth26dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS Arnold, Maryland	
3. NAME OF DECEASED (Type or print) Charles Derschinger		4. DATE OF DEATH Month Sept. Day 7 Year 1959	
5 SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1874
9 AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired potter		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Martin Derschinger		14. MOTHER'S MAIDEN NAME Elizabeth Alt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia and pulmonary abscesses 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 8, 1957 to Sept. 7, 1959 , that I last saw the deceased alive on Sept. 7, 1959 , and that death occurred at 9:30 a.m. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslar M D SPRING GROVE STATE HOSPITAL 9-8-59			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/11/59	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Licknerthaus		ADDRESS At Pa Ave	
24a. REC'D BY REGISTRAR DATE SEP 9 1959		24b. REGISTRAR'S SIGNATURE Arthur B. Rie	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. 70 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

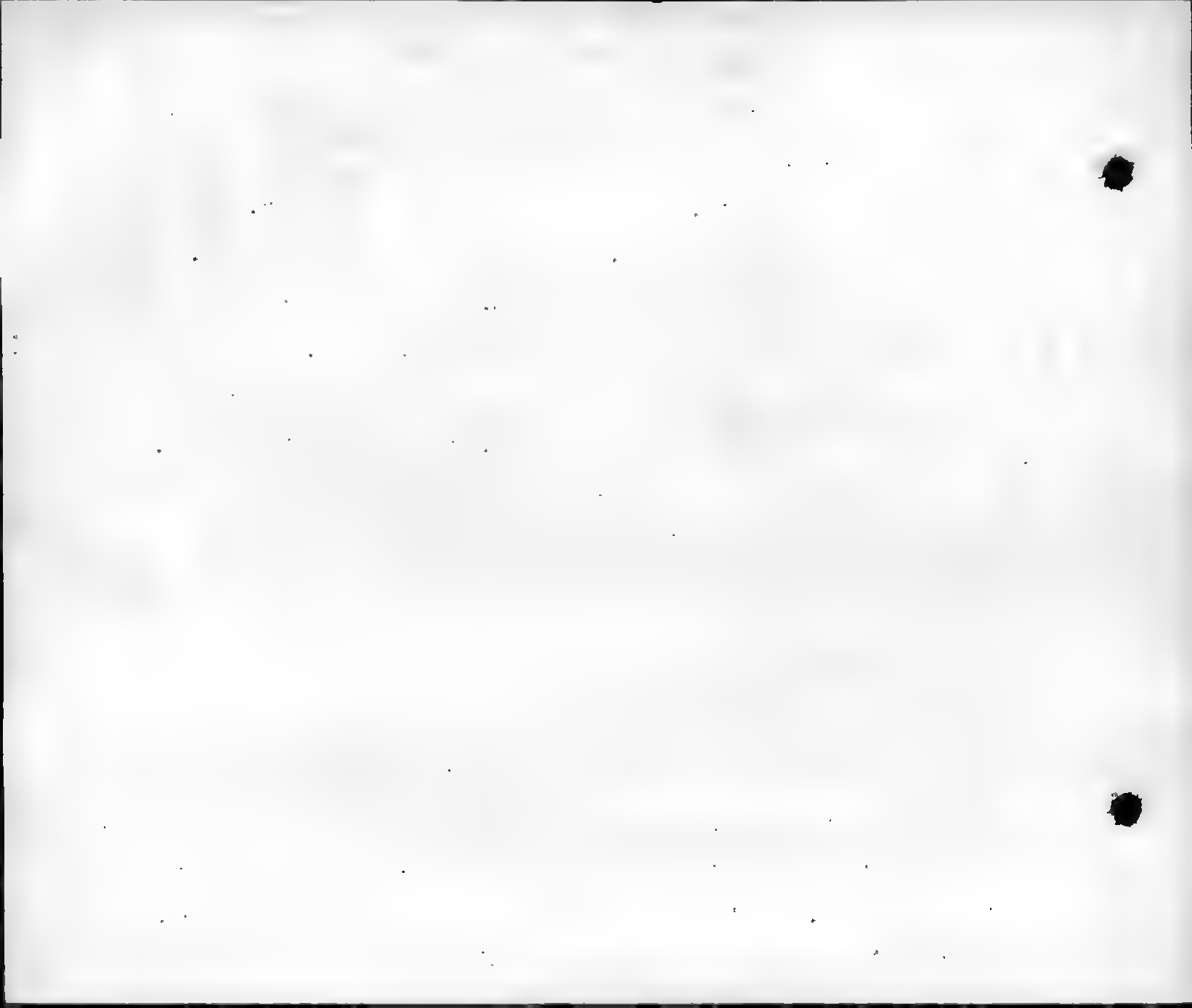
09949

CERTIFICATE OF DEATH

Reg. Dist. No

09914

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4321 Kenwood Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>M.</u> Last <u>Dietel</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Neubauer</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine Bodenschatz</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>John T. Dietel 4321 Kenwood Ave. 6</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive Cardiovascular Dis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>			INTERVA. BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>Many years</u> <u>Many yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 1953 to <u>Sept 16</u> , 1959, that I last saw the deceased alive on <u>Sept 16</u> , 1959, and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Max R. English</u> M.D.		ADDRESS (Street, city or town, state) <u>5713 Belair Rd</u> DATE SIGNED <u>9-17-59</u>	
PHYSICIAN'S NAME (Type) <u>Max R. ENGLISH M.D.</u>		<u>Baltimore 6 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 19, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Garrett Funeral Home</u>		ADDRESS <u>7401 Belair Rd</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09915

09959

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1906 Indian Head Rd				d. STREET ADDRESS 1906 Indian Head Rd			
3. NAME OF DECEASED (Type or print) First Middle Last MATTISON HENRY DOUGHTY				4. DATE OF DEATH Month Day Year Sept. 15, 1959 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1877	9. AGE (In years last birthday) yrs. 82	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Doughty				14. MOTHER'S MAIDEN NAME Elizabeth Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 712-14-3956		17. INFORMANT Address Mrs. Robt. W. Jenkins-1906 Indian Head Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Scirrhus carcinoma of left ear with 197.1 DUE TO generalized metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 21, 1959 to Sept. 15, 1959 , that I last saw the deceased alive on Sept. 14, 1959 , and that death occurred at 9:45 A. M. from the causes and on the date stated above							
ACTUAL SIGNATURE <i>Lloyd E. Saylor</i>		M.D. 3902 Greenmount Avenue		DATE SIGNED 9/15/59		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) Lloyd E. Saylor, M. D.		Baltimore 18, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/18/59		22c. NAME OF CEMETERY OR CREMATORY Fairmount		22d. LOCATION (City, town, or county) (State) East Orange, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. 1050 York Rd. Towson				24a. REC'D BY REGISTRAR DATE SEP 17 '59		24b. REGISTRAR'S SIGNATURE <i>William E. Frank</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09951

CERTIFICATE OF DEATH

Reg. Dist. No. 09915
32

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution Residence before admission] a. STATE <u>md</u> b. COUNTY <u>Carroll</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>			c. LENGTH OF STAY IN lb <u>29 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				d. STREET ADDRESS <u>44 Central Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Ann Earle</u>				4. DATE OF DEATH Month Day Year <u>Sept 9 1959</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-18-83</u>		
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS		11. BIRTHPLACE (State or foreign country) <u>Sheppards town W. Va.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hom.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Moses A Kimes</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Miller</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DDX</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>8-11-1959</u> to <u>9-9-1959</u> , that I last saw the deceased alive on <u>9-9-1959</u> , and that death occurred at <u>12:58 PM</u> , from the causes and on the date stated above.				
ACTUAL SIGNATURE <u>William Newcomer</u> M.D.				ADDRESS (Street, city or town, state) <u>Mt. Wilson, Maryland</u>		DATE SIGNED <u>9-9-59</u>		
PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D.</u>				<u>Superintendent</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>9-12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. James, Carroll Co., Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kimes</u>				ADDRESS <u>St. James, Carroll Co., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 14 '59</u>		
24b. REGISTRAR'S SIGNATURE <u>Charles E. Kimes</u>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09917

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Overlea													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7401 Kenlea Ave.				d. STREET ADDRESS 7401 Kenlea Ave.													
3. NAME OF (Type or print) Samuel Robert Eberline				4. DATE OF DEATH Month Sept. Day 5 Year 19 59													
5. SEX M		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>													
8. DATE OF BIRTH May 16, 1893		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Market		11. BIRTHPLACE (State or foreign country) Balto. Md.													
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME August Eberline													
14. MOTHER'S MAIDEN NAME Elizabeth Horner				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No													
16. SOCIAL SECURITY NO. 218-32-0786		17. INFORMANT Address Mrs. Elizabeth Eberline 7401 Kenlea Ave.															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 163X </td> <td> MASSIVE HEMOPTYSIS </td> </tr> <tr> <td colspan="2"> DUE TO </td> <td> Carcinoma of lung, right </td> </tr> <tr> <td colspan="2"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td> DUE TO </td> </tr> <tr> <td colspan="2"> (b) </td> <td> (c) </td> </tr> </table>						PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 163X		MASSIVE HEMOPTYSIS	DUE TO		Carcinoma of lung, right	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO	(b)		(c)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 163X		MASSIVE HEMOPTYSIS															
DUE TO		Carcinoma of lung, right															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO															
(b)		(c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)													
20f. (City or town)		(County)		(State)													
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <i>W. Bradley King, Jr.</i>		EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>													
DATE SIGNED Sept. 6, 1959																	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 8, 1959		22c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith													
22d. LOCATION (City, town, or county) Baltimore, Md.		(State)															
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lorraine Lorraine</i>		ADDRESS 7401 Kenlea Ave.		24a. REC'D BY REGISTRAR DATE SEP 8 '59													
24b. REGISTRAR'S SIGNATURE <i>Charles L. Hume</i>																	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1, 2, and 3 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 2 X 09953 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Filed 1959-9-28-59 et

CERTIFICATE OF DEATH

09918

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> c. LENGTH OF STAY IN TB <u>3 wks</u> d. NAME OF HOSPITAL (If not in hospital, give street address) (Private OR INSTITUTION) <u>1709 Reisterstown Road (home)</u>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>#7 Georgia Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marie M. Eckman</u>		4. DATE OF DEATH Month Day Year <u>Sept- 19, 1959</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>16 January 1898</u>		9. AGE (In years last birthday) <u>61</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 25 HRS</td> </tr> <tr> <td>Months Days Hours Min</td> <td></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 25 HRS	Months Days Hours Min	
IF UNDER 1 YEAR	IF UNDER 25 HRS																
Months Days Hours Min																	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Unknown (Schaefer)</u>						14. MOTHER'S MAIDEN NAME <u>Margaret (Unknown)</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>None</u>				17. INFORMANT <u>Charles M. Eckman - Same As #2</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremic coma</u> (c) <u>Hypertensive Cardiovascular Renal Disease</u>												INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>					
												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left hemiplegia</u>																	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>Sept 14 1959</u> to <u>Sept 19, 1959</u> , that I last saw the deceased alive on <u>Sept 18, 1959</u> , and that death occurred at <u>3 a.</u> M. from the causes and on the date stated above.																	
ACTUAL SIGNATURE <u>Louis R. Maser</u> M.D.				ADDRESS (Street, city or town, state) <u>4335 Park Heights Ave</u>				DATE SIGNED <u>9/19/59</u>									
PHYSICIAN'S NAME (Type) <u>L.R. MASER M.D.</u>																	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>21 Sept-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.V. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>						24a. REC'D BY REGISTRAR <u>DATE SEP 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Orlino & Kruus</u>									



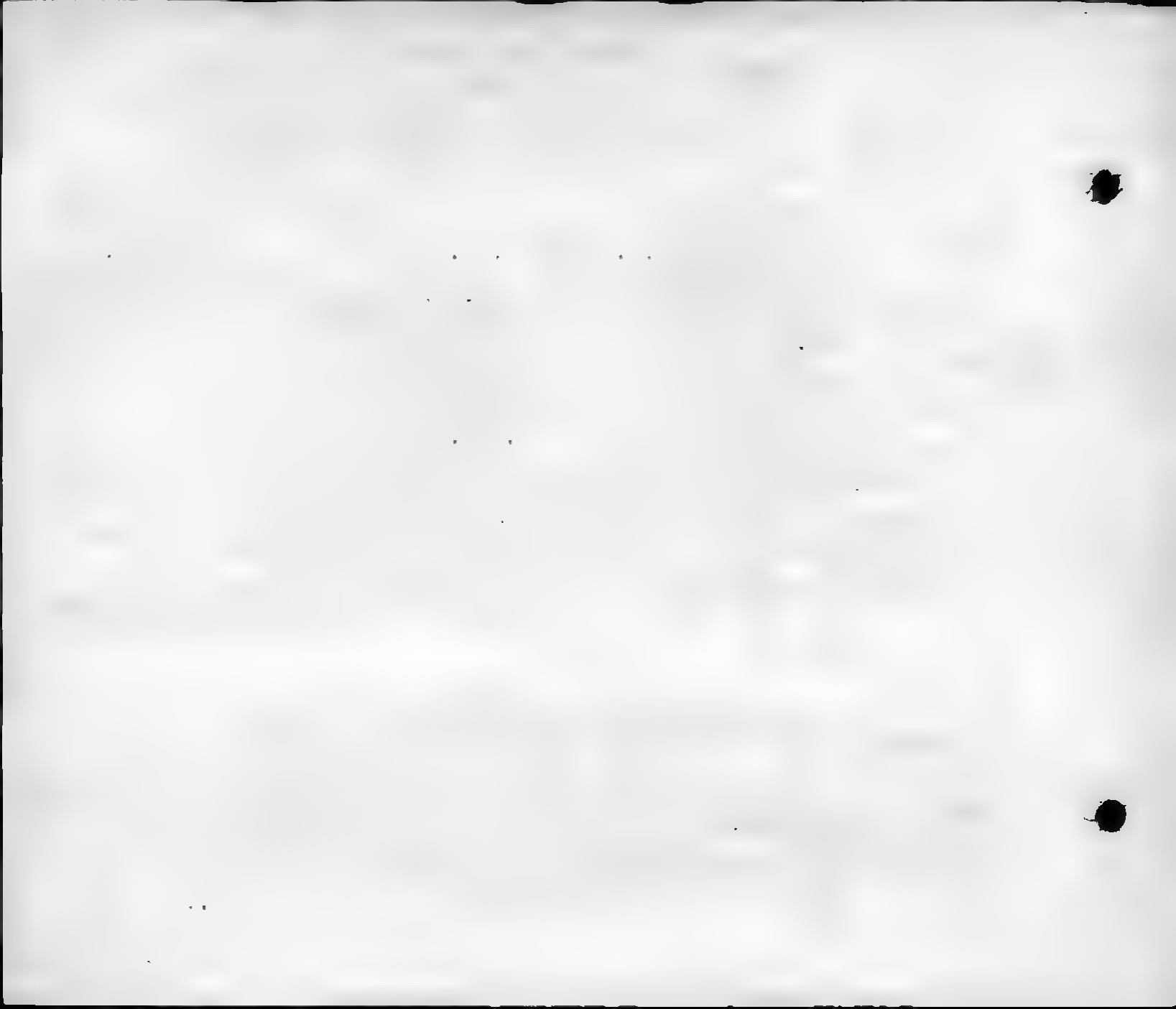
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3030 Dunglew Road		d STREET ADDRESS 3030 Dunglew Road	
3. NAME OF DECEASED (Type or print) First Middle Last ADOLPHUS H.D. EDWARDS, Sr.		4. DATE OF DEATH Month Day Year September 22, 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1871
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cold Roll Supt.		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (State or foreign country) Wales		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Edwards		14. MOTHER'S MAIDEN NAME Jeanette ??	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-10-6494	
17. INFORMANT Mrs. Wm. Vitek		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 hr. 5 yrs.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1949 to Sept 22, 1959 that I last saw the deceased alive on Sept 22, 1959 and that death occurred at 11 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE David H. Andrew		DATE SIGNED 9/24/59	
PHYSICIAN'S NAME (Type) David H. Andrew		ADDRESS (Street, city or town, state) 33 Dundalk Ave Dundalk Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/25/59	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial	22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley & Son		24a. REC'D BY REGISTRAR DATE SEP 28 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

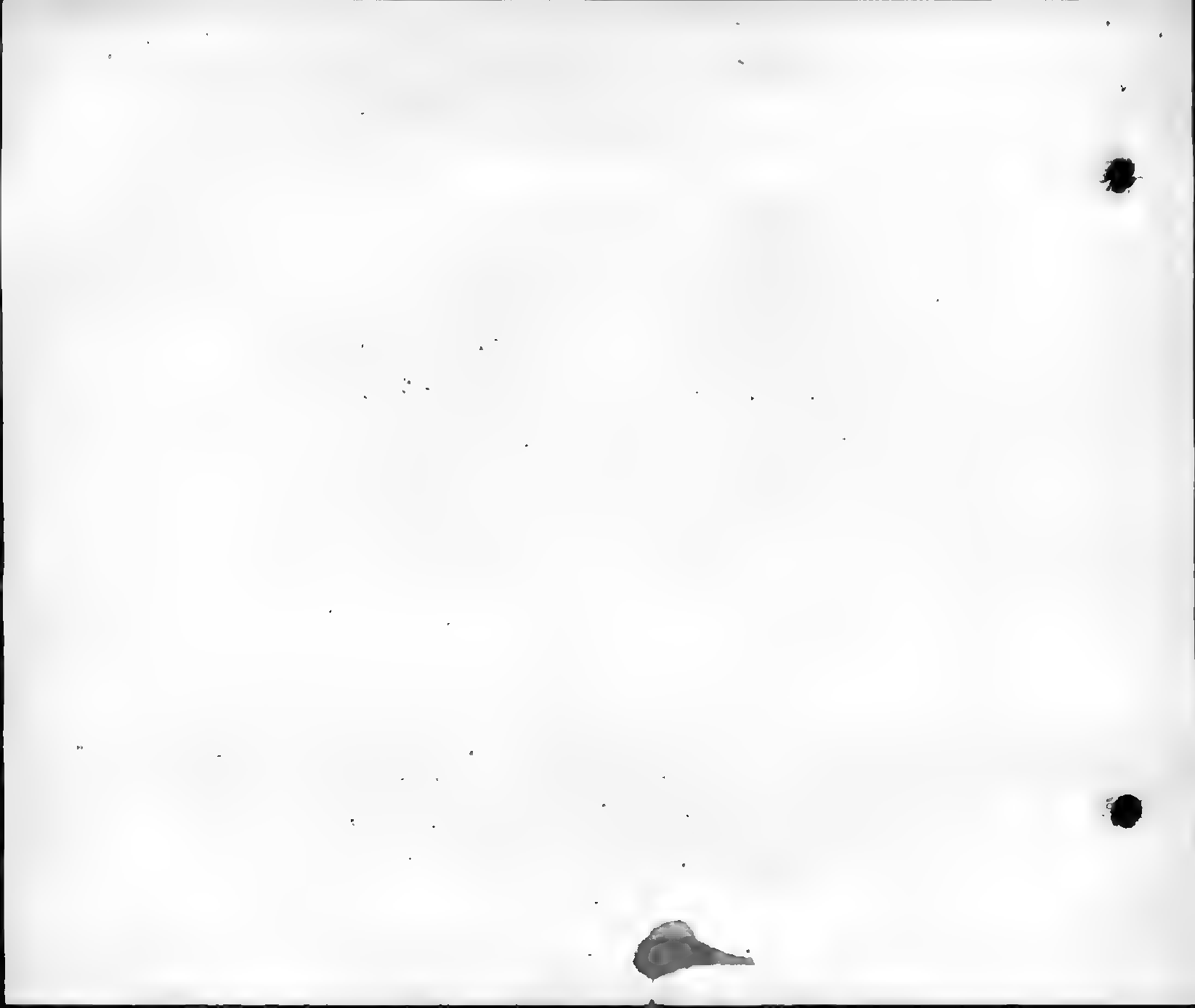
Reg. Dist. No.

09954

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 29 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle A Last EULER		4. DATE OF DEATH Month September Day 30 Year 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 18, 1878
9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months 00 Days 00 Hours 00 Min 00	11. IF UNDER 24 HRS Hours 00 Min 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Millinery	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ned Euler (Edwin J. Euler)		14. MOTHER'S MAIDEN NAME Augusta Kabernagel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give year or dates of service) Yes OW		16. SOCIAL SECURITY NO. 217-01-4849	
17. INFORMANT Clin. Rec. Vet. Adm. Hospital Ft. Howard, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 17 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 DAYS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adenocarcinoma of ascending colon, removed April, 1958		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 1, 1959 to September 30, 1959 , and that death occurred at 1:13 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Crawford		ADDRESS (Street, city or town, state) VAH Ft. Howard, Md	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, MD.		DATE SIGNED 9/30/59	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 10-3-59	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) 3801 Frederick Ave. Balto. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons Inc. North & Pennsylvania		24a. REC'D BY REGISTRAR NOV 1 '59	
ADDRESS Balto. Md		24b. REGISTRAR'S SIGNATURE Arthur A. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

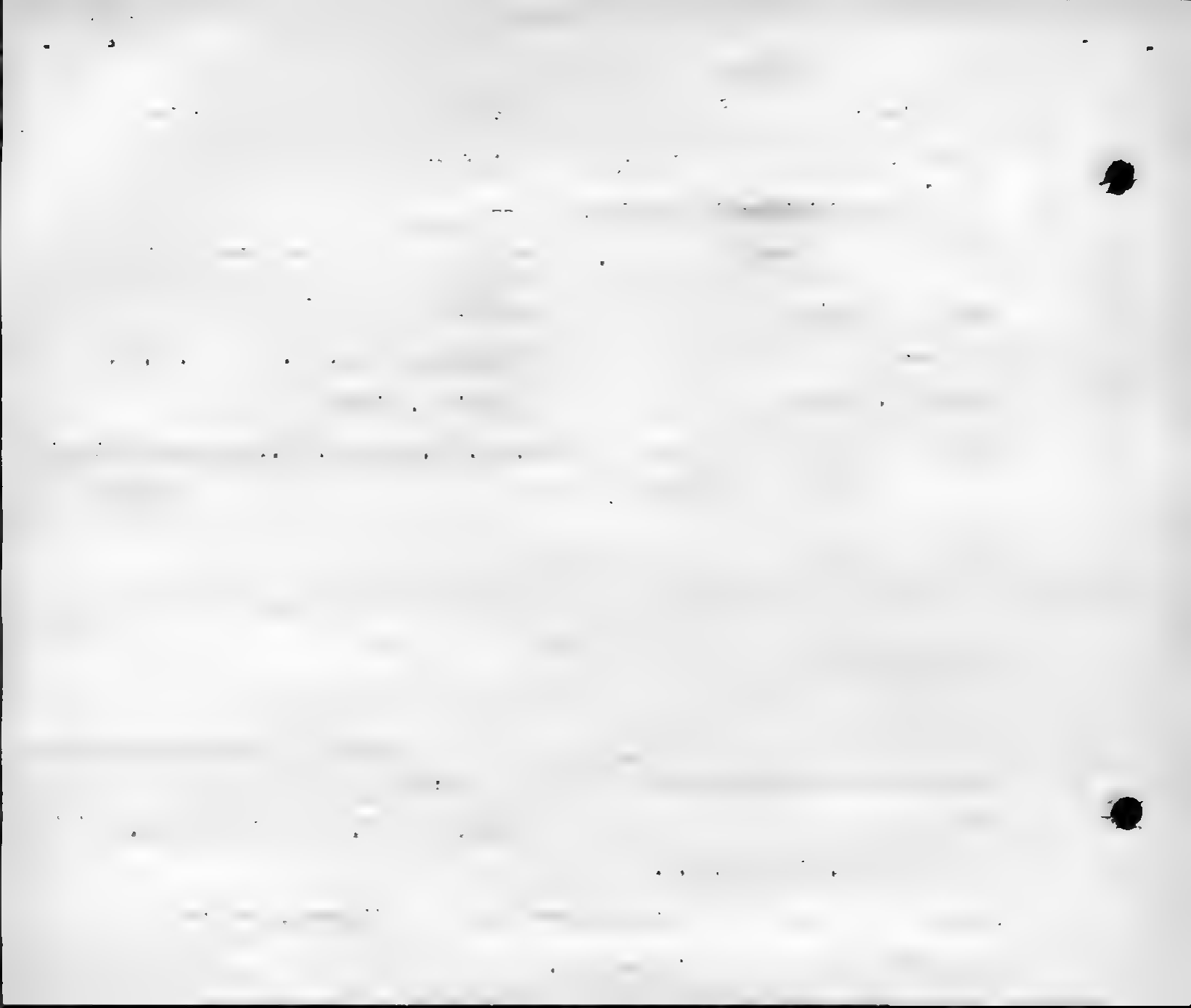
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Howard		c. LENGTH OF STAY IN 1b 15 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MERRELL Middle H. Last EVANS		4. DATE OF DEATH Month September Day 1 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1896
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman	
10b. KIND OF BUSINESS OR INDUSTRY Oyster		11. BIRTHPLACE (State or foreign country) Hollands Island, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME George T. Evans	
14. MOTHER'S MAIDEN NAME Lottie C. Wilson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec. VAH, Balte 18, Md., Fort Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from August 17, 1959 to September 1, 1959 and that death occurred at 8:20 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO MD. Y FORT HOWARD DIV. DATE SIGNED 9/1/59			
ACTUAL SIGNATURE John W. Crawford M.D. JOHN W. CRAWFORD, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/4/59	22c. NAME OF CEMETERY OR CREMATORY Tilghman Cemetery
22d. LOCATION (City, town, or county) Tilghman, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John Leeds Moore		ADDRESS Tilghman, Md.	
24a. REC'D BY REGISTRAR DATE SEP 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09922

09904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highlands</u> c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4012 Annapolis Road.</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Highlands</u> d. STREET ADDRESS <u>4012 Annapolis Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank J. Faulkner</u>		4. DATE OF DEATH Month Day Year <u>September 2 1950</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 26 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Capitan</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Book Retailer</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathan Faulkner</u>		14. MOTHER'S MAIDEN NAME <u>Leontine</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>r</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>9. 5. 50</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Kelly</u>		ADDRESS <u>130 E. Fort Ave.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>SEP 4 1950</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09923

09956

CERTIFICATE OF DEATH

Reg. Dist. No.

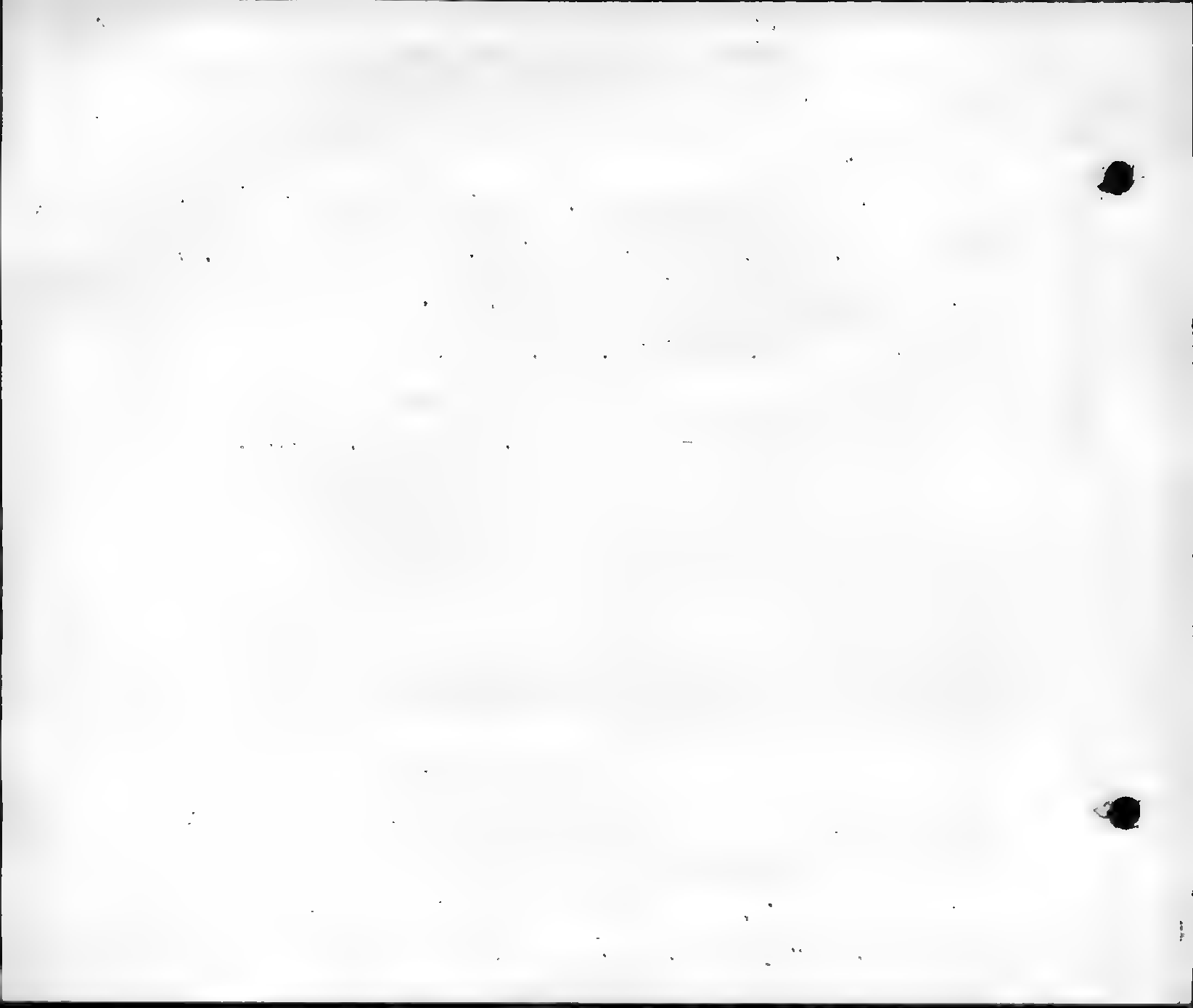
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7807 Westmoreland Ave.</i>		e. STREET ADDRESS <i>7807 Westmoreland Avenue</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mr. Karl Joseph Finger</i>		4. DATE OF DEATH Month Day Year <i>Sept. 10, 1959</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 10, 1888</i>
9. AGE (In years last birthday) <i>70</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Continental Can Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Finger</i>		14. MOTHER'S MAIDEN NAME <i>Bertha Kolloch</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>212-03-3408</i>	
17. INFORMANT <i>Mrs. Augusta G. Finger,</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the head of the pancreas</i> <i>157X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>9/12 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-25</i> , 19 <i>59</i> to <i>9-10</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>9-9</i> , 19 <i>59</i> , and that death occurred at <i>3:05 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>7122 Harford Rd, Baltimore 15 Md</i> ACTUAL SIGNATURE <i>Joseph Finger</i> M.D. PHYSICIAN'S NAME (Type) <i>22</i>			
22a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/15/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem Park</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24. REC'D BY REGISTRAR DATE <i>SEP 14 '59</i>	
25. ADDRESS <i>5305 Harford Road #14</i>		26. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

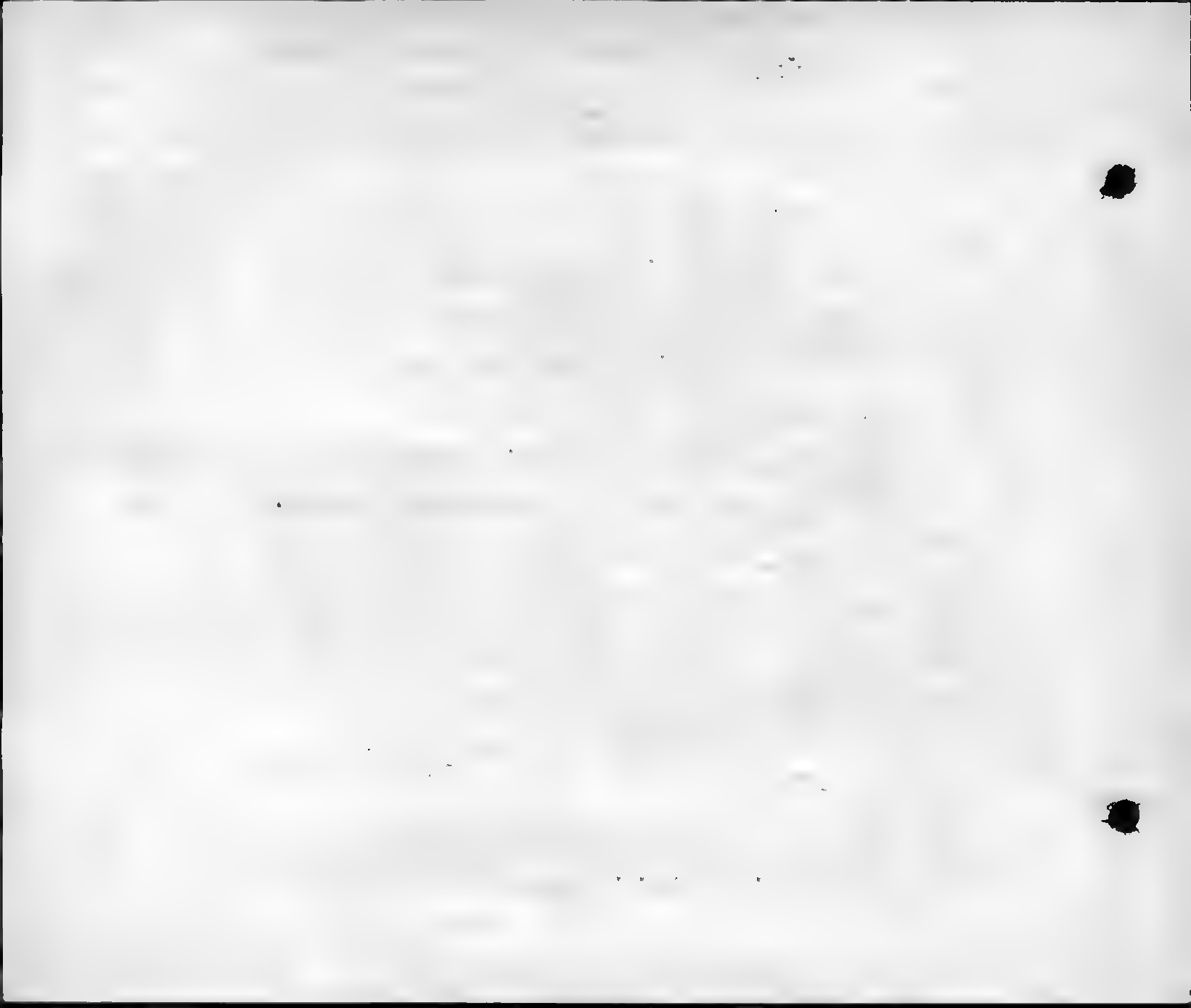
03924

09957

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1812 Deveron Road</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u> d. STREET ADDRESS <u>1812 Deveron Road #4</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>A. XXXXX</u> Last <u>FINK</u>				4. DATE OF DEATH Month <u>September</u> Day <u>11</u> Year <u>19 59</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 26, 1880</u>		9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Inspector</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Transit</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Adam ?</u>						14. MOTHER'S MAIDEN NAME <u>Caroline ?</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-03-4328</u>				17. INFORMANT Address <u>Mrs. Margaret E. Settle-1812 Deveron Road #4</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> DUE TO (c) <u> </u> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u> </u> </div> </div>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>									
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. Month, Day, Year <u> 19 </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Partial</u>		20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Charles S. Petty</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>Charles S. Petty, M.D.</u>						DATE SIGNED <u>9/12/59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Louder Park Cemetery</u>				22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lichten & Sons</u>						ADDRESS <u>Balto - 17, Md.</u>							
24a. REC'D BY REGISTRAR DATE <u>SEP 15 '59</u>						24b. REGISTRAR'S SIGNATURE <u>Calvin S. Hines</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09925

09958

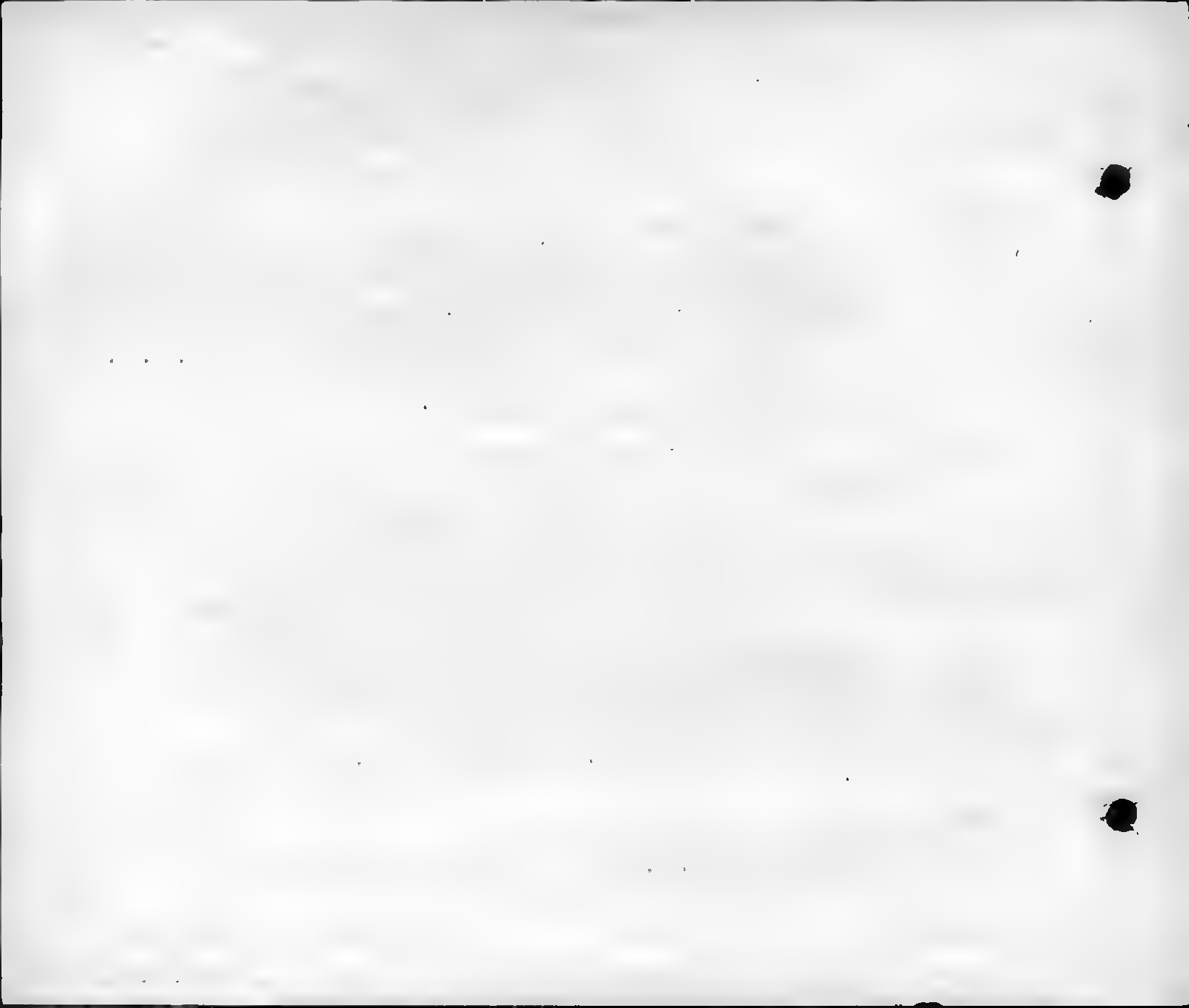
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 9mth13dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 2028 Eagle Street	
3 NAME OF DECEASED (Type or print) Michael Fischhaber Fishhaber		4. DATE OF DEATH Month September Day 4 Year 19 59	
5 SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1988 Mar. 15
9a. AGE (In years, last birthday) 71 yrs		9. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) baker		10b. KIND OF BUSINESS OR INDUSTRY BAKING	
11 BIRTHPLACE (State or foreign country) Germany		12 CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Joseph Fishhaber		14 MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unknown NONE		16 SOCIAL SECURITY NO 216-03-2435	
17 INFORMANT Recorded: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorenal failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 20, 1958 , to Sept. 4, 1959 , that I last saw the deceased alive on Sept. 4, 1959 , and that death occurred at 8:35 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9-4-59			
ACTUAL SIGNATURE Stella Wachslar		M. D. SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-7-59	22c NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEMORIAL	22d LOCATION (City, town, or county) (State) ELK Ridge, Md.
23 FUNERAL DIRECTOR'S SIGNATURE John A. Schura		ADDRESS General Home 2161 Frederick Ave.	
24a REC'D BY REGISTRAR SEP 8 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

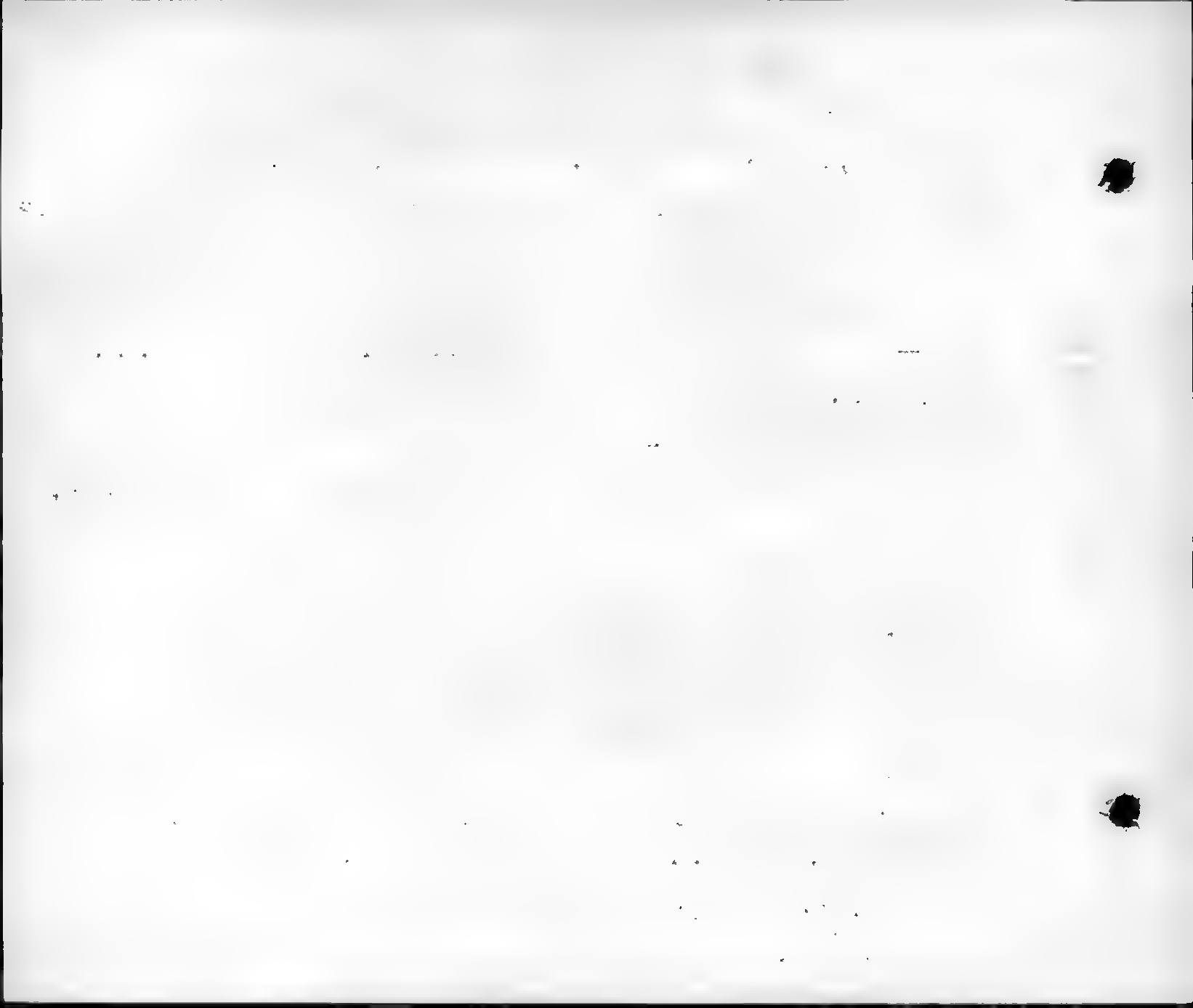
Reg. Dist. No.

09959

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland c. LENGTH OF STAY IN 1b 46 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland d. STREET ADDRESS 2339 Druid Hill Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Isaac Middle Fletcher Last Fletcher		4. DATE OF DEATH Month 9 Day 4 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/15/96
9. AGE (In years lost birthday) 62 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 62 Days 62 Hours 62 Min 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Boston, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LATE Barnett Fletcher		14. MOTHER'S MAIDEN NAME Esther Lesser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. -----	
INFORMANT Rosewood Records		Address -----	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diarrhea with severe dehydration DUE TO (b) 178.6 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) ----- DUE TO (c) -----			INTERVAL BETWEEN ONSET AND DEATH 30 hours.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinsonian Syndrome since 1945			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o m. 19 p. m. -----	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that I attended the deceased from 1943 , 19 ----- , to 9/4 , 19 59 that I last saw the deceased alive on 9/4 , 19 59 , and that death occurred at 4:10 A.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) ----- DATE SIGNED -----			
ACTUAL SIGNATURE Viola B. Johns		M.D. Rosewood State Training School 9/4/59	
PHYSICIAN'S NAME (Type) Viola B. Johns, M.D.		Owings Mills, Maryland	
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 6/59	22c. NAME OF CEMETERY OR CREMATORY BETH YEHUDA ANSHE KURLAND	22d. LOCATION (City, town, or county) (State) BALTIMORE, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Sal Levinson		24a. REC'D BY REGISTRAR SEP 9 '59	
ADDRESS 1124 W. North		24b. REGISTRAR'S SIGNATURE Arthur L. Kneiss	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Filed 2-18-59 at

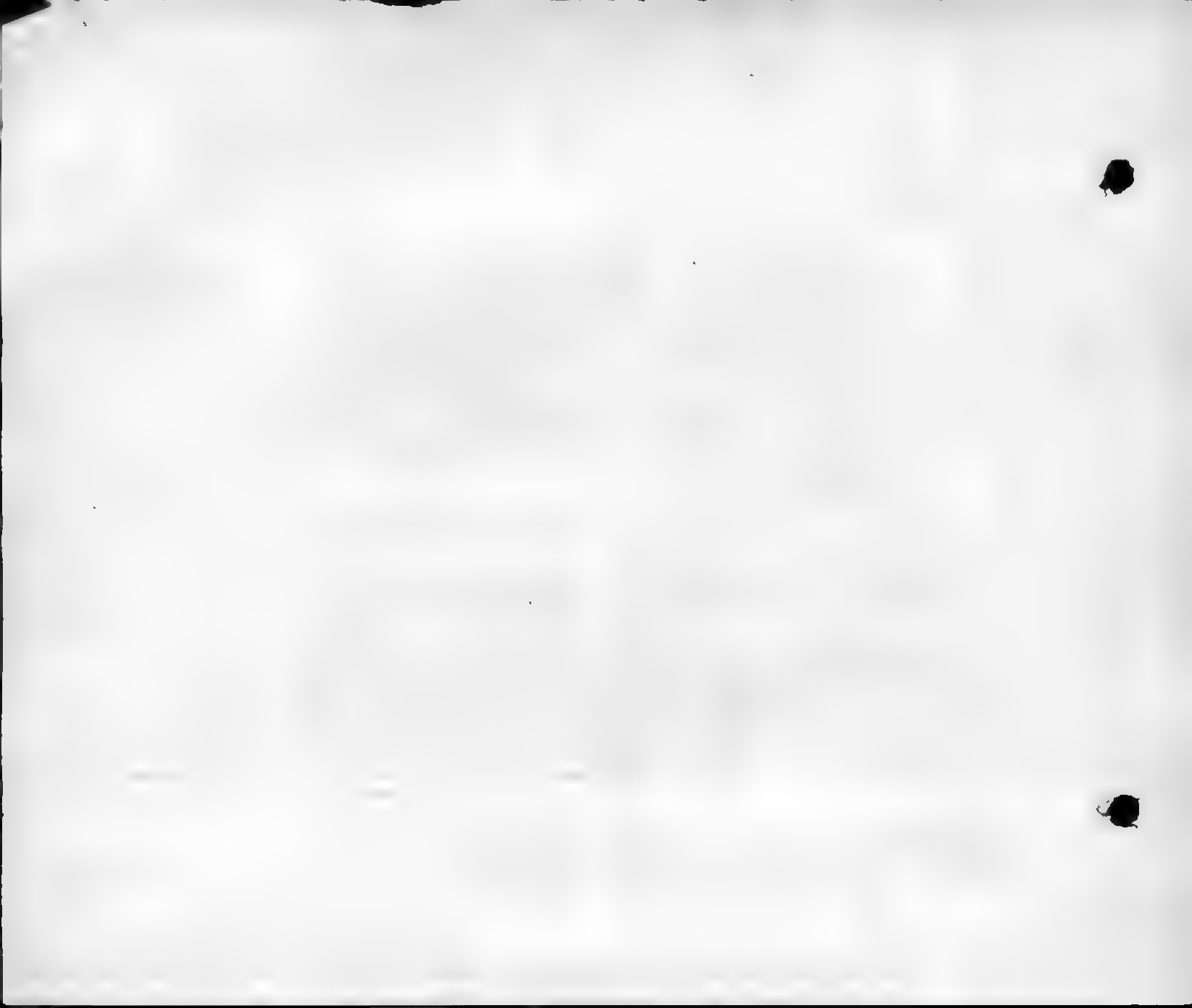
CERTIFICATE OF DEATH

05927

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Balt</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House of Aches 16 Trusting ave</i>		d. STREET ADDRESS <i>900 E Randall</i> 15	
3. NAME OF DECEASED (Type or print) <i>William A. Fritz</i> First Middle Last		4. DATE OF DEATH Month <i>Sept</i> Day <i>11</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 12, 1879</i> 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Proctor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>	
11. BIRTHPLACE (State or foreign country) <i>Balt</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Adam Fritz</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Siegle</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Henry Fritz</i> Address <i>15 Paultray W</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio-sclerotic Heart Disease</i> DUE TO <i>Generalized arterio-sclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9/2</i> , 19 <i>59</i> , to <i>9/14</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>9/6</i> , 19 <i>59</i> , and that death occurred at <i>19</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Harry Deibel</i> M.D. <i>1226 Hammar St Balt 36</i>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>DR. HARRY DEIBEL</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept 14, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Pk</i>		22d. LOCATION (City, town, or county) (State) <i>Balt Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Evans</i> ADDRESS <i>1400 Schantz</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 15 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kenna</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove pages 1 and 2 and file them with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

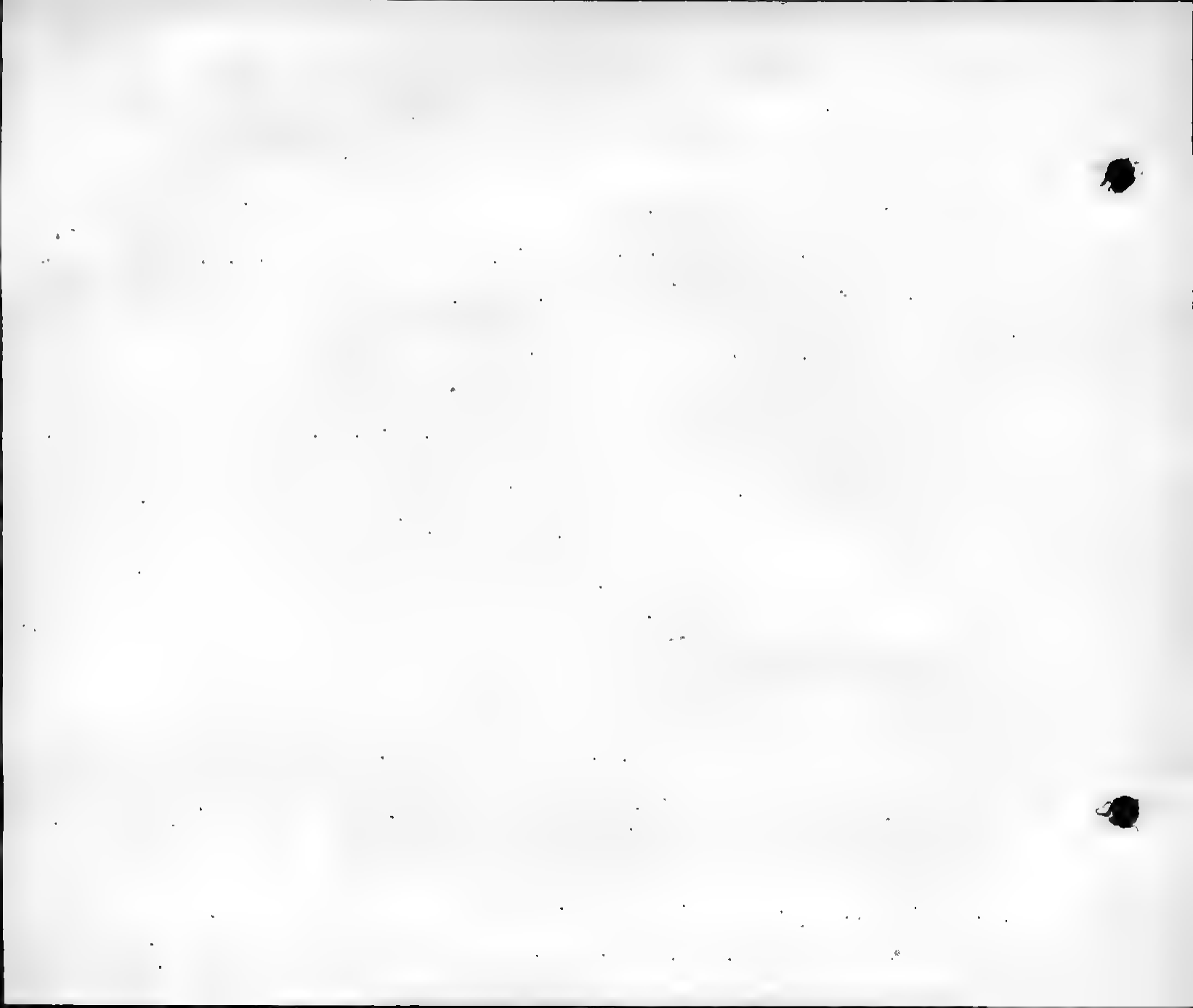
09961

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson - 4		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1413 Putty Hill Rd.		d. STREET ADDRESS 4 East 32nd St.	
3. NAME OF DECEASED (Type or print) First MIRIAM Middle BOWLES Last GILE		4. DATE OF DEATH Month Sept. Day 4 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1901
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interviewer, Md. Dept. of Employment Security - Maryland		10b. KIND OF BUSINESS OR INDUSTRY USA	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ? Bowles		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. INFORMANT Rexford R. Gile, Jr. 1413 Putty Hill Rd. 4	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) UREMIA Clinically 154X DUE TO Carcinoma Metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO Carcinoma of Rectum (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Days weeks months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/3/59 to 9/4/59 , that I last saw the deceased alive on 9/3/59 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William F. Kelly, Jr. M.D.		ADDRESS (Street, city or town, state) 1526 Stonewood Rd. Baltimore Md.	
PHYSICIAN'S NAME (Type) William F. Kelly, Jr.		DATE SIGNED 9/4/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Sept. 7, 1959	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC. Baltimore Md.		24a. REC'D BY REGISTRAR SEP 8 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Fries			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII A15 (4)
ISM 9/58



1A
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09929

09962 items 8,9 Film 6248 9-21-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7330 GERMAN HILL RD.</u>			d. STREET ADDRESS <u>7330 GERMAN HILL RD.</u>		
3. NAME OF DECEASED (Type or print) <u>BOLESZAW (Ben) GRABOWSKI</u>			4. DATE OF DEATH Month <u>SEPT.</u> Day <u>8</u> Year <u>1959</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/29/89</u>	9. AGE (In years last birthday) <u>69</u>	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATE MIXER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>RUBEROID CO.</u>		
11. BIRTHPLACE (State or foreign country) <u>POLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>IGNATIUS GRABOWSKI</u>			14. MOTHER'S MAIDEN NAME <u>M. N. NOWAK</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>213-01-5394</u>		
17. INFORMANT <u>BERNARD GRABOWSKI</u>			Address <u>2507 Gough St.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO <u>ASC-U DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASC-U DISEASE</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>M. B. Davis</u>			DATE SIGNED <u>9/10/59</u>		
EXAMINER'S NAME (Type) <u>M. B. Davis M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>SEPT. 12, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART MARY</u>	22d. LOCATION (City, town, or county) <u>BALTIMORE</u>	(State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>RAYMOND L. HACHOWSKI</u>			24. REGISTRAR'S SIGNATURE <u>Arthur J. Kinn</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



09963

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown			
c. LENGTH OF STAY IN 1b 42 years				d. STREET ADDRESS Berryman's Lane			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Berryman's Lane				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lena Middle Wilhelmina Last Green				4. DATE OF DEATH Month September Day 19 Year 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 1 1914		9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Vaughn				14. MOTHER'S MAIDEN NAME Katherine Gauss			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-18-0313		17. INFORMANT John W Green Owings Mills Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410X due to Inflammation, rheumatism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - (c) -						INTERVAL BETWEEN ONSET AND DEATH 20 years or more	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1-1-1914 to 9-19-59 , that I last saw the deceased alive on 9-18-59 , and that death occurred at 4:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James G. Saffell M.D.				ADDRESS (Street, city or town, state) Reisterstown Md			
PHYSICIAN'S NAME (Type) James G. Saffell M.D.				DATE SIGNED 9-21-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 22 1959		22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		22d. LOCATION (City, town, or county) (State) Reisterstown Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Berryman + Sons				ADDRESS Reisterstown Md		24a. REC'D BY REGISTRAR DATE SEP 22 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the General Director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



09964

CERTIFICATE OF DEATH

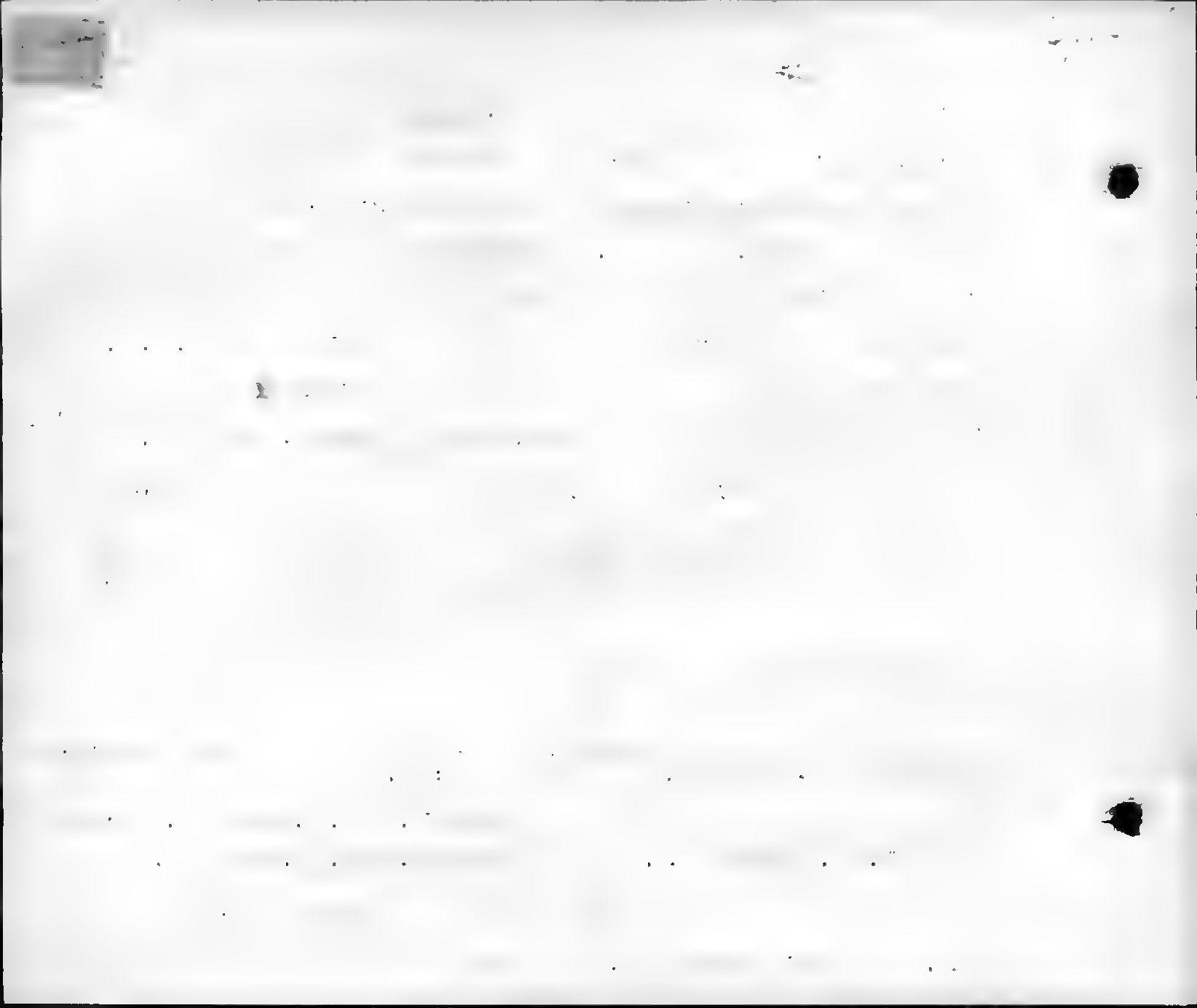
Reg. Dist. No.

09933

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 12 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 2000 Eastern Avenue			
3. NAME OF DECEASED (Type or print) First EDWARD Middle A. Last GRYNKIEWICZ				4. DATE OF DEATH Month September Day 9 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1899	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Tavern		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Vincent Gryniewicz				14. MOTHER'S MAIDEN NAME Sophia Bernadzikowski			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) Yes		16. SOCIAL SECURITY NO. 7/20-17-8/7/19 217-32-256		INFORMANT Address Clin. Records, VA Hospital, Balto. 18, Md. Ft. Howard			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA 162.1 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) BRONCHOPNEUMONIA (c) PULMONARY ABSCESS PULMONARY HEART DISEASE						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN RECENT RECENT RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) VA	(County)	(State)		
21. I certify that I attended the deceased from August 28 , 19 59 , to September 9 , 19 59 , and that death occurred at 5:45 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO. 18, MD. FT. HOWARD DIV. DATE SIGNED 9/9/59							
ACTUAL SIGNATURE <i>John W. Crawford</i>		M.D. VAH, BALTO. 18, MD. FT. HOWARD DIV.					
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH, BALTO. 18, MD., FT. HOWARD DIV.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/12/59	22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. S. Fialowski		ADDRESS 2007 Eastern Ave. Balto 31, Md.		24a. REC'D BY REGISTRAR DATE SEP 10 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>		

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09934

09965

CERTIFICATE OF DEATH

Reg. Dist. No.

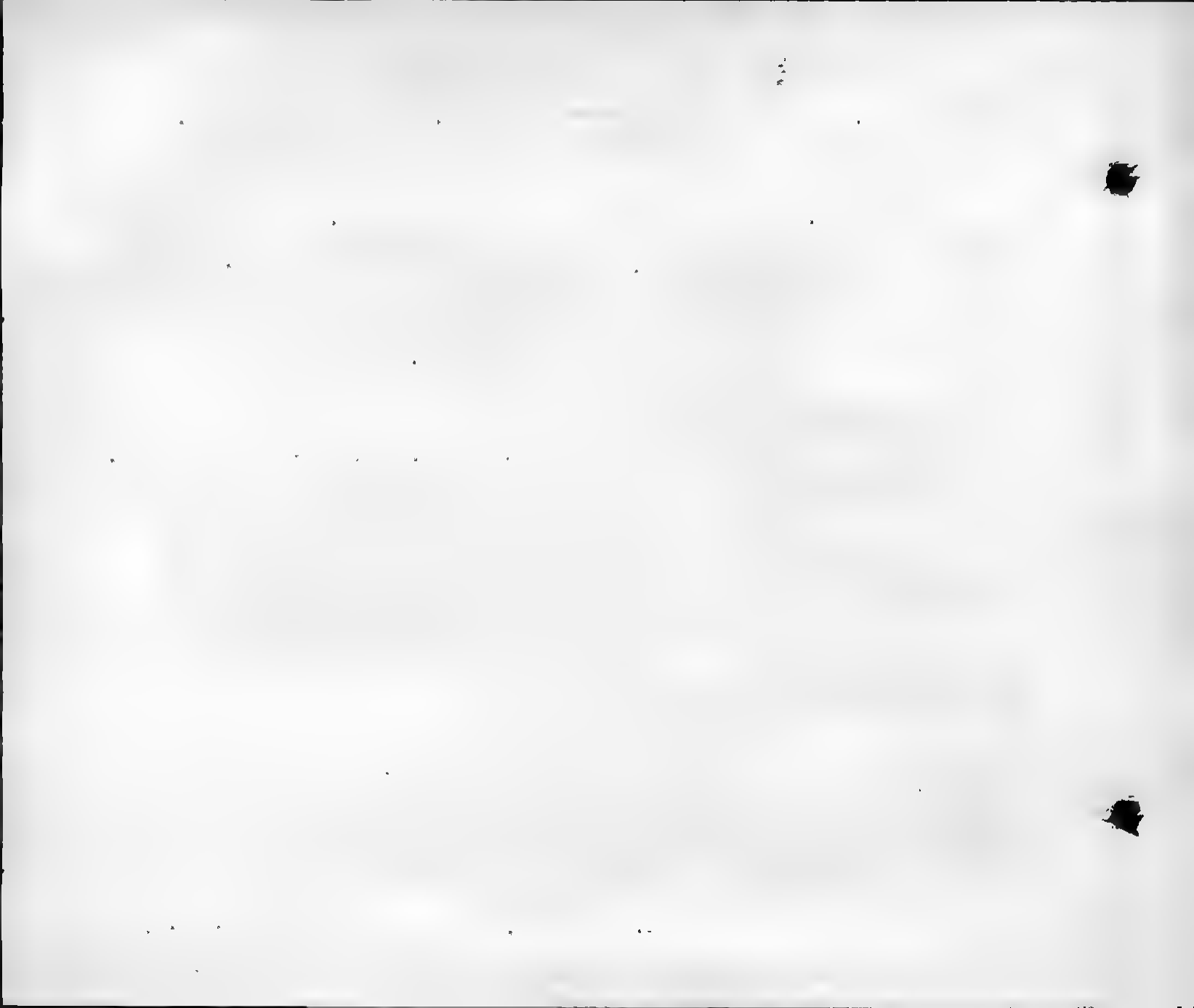
1 PLACE OF DEATH a. COUNTY <u>Balto Co</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> c. LENGTH OF STAY IN 1b <u>30</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>38 E Federal Dr</u>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> d. STREET ADDRESS <u>38 E Federal Dr</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Louise</u> Last <u>Hahn</u>		4 DATE OF DEATH Month <u>Sept</u> Day <u>11</u> Year <u>1959</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-19-1873</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE (In years last birthday) <u>86</u> yrs
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Carl DeNeque</u>		14. MOTHER'S MAIDEN NAME <u>Hannah S Kruger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Lawrence M. Lender</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic cardiovascular disease</u> DUE TO (c) <u>10 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 wks</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar</u> 19 <u>55</u> to <u>Sept 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 11</u> , 19 <u>59</u> , and that death occurred at <u>9:30 A M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis Scienceff</u>		ADDRESS (Street, city or town, state) <u>2108 O REMS RD</u> DATE SIGNED <u>9/11/59</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS SCIENCEFF</u>		<u>Baltimore 20, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Removal</u>	<u>9-3-1959</u>	<u>Wasson Cemetery - Wasson Wisconsin</u>	<u>Wasson Wisconsin</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Buginski</u>		ADDRESS <u>1407 Eastern Ave 21 Md</u>	
24a REC'D BY REGISTRAR		24b REGISTRAR'S SIGNATURE	
DATE <u>SEP 14 '59</u>		<u>Carling & House</u>	



09935

09905

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND						2 USUAL RESIDENCE (Where deceased lived. If institution Residence before adm ssion) a. STATE Md. b. COUNTY Balto.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				c. LENGTH OF STAY IN 1b Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				d STREET ADDRESS 1271 Birch Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN T. HAMMOND						4. DATE OF DEATH Month Day Year Sept. 8, 19 59									
5 SEX male		6 COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1896		9 AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Md.				12 CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME John Worthington Hammond						14. MOTHER'S MAIDEN NAME Mary Anna Shipley									
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16 SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Ruth H. Hammond - 1271 Birch Ave. #27											
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of prostate 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____												INTERVA. BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 1958 to Sept 8, 1959, that I last saw the deceased alive on Sept 7, 1959, and that death occurred at 2:10 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state). DATE SIGNED E. E. APPL. PASS M.D. Dr. J. W. Williams Aug 4-8-59															
ACTUAL SIGNATURE															
PHYSICIAN'S NAME (Type)															
22a BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/11/59		22c. NAME OF CEMETERY OR CREMATORY St. Johns Cem.		22d LOCATION (City, town, or county) (State) Ellicott City, Md.							
23 FUNERAL DIRECTOR'S SIGNATURE William L. Schmitt				ADDRESS New-Baltimore		24a. REC'D BY REGISTRAR DATE SEP 9 1959		24b REGISTRAR'S SIGNATURE William L. Schmitt							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09936

09966

CERTIFICATE OF DEATH

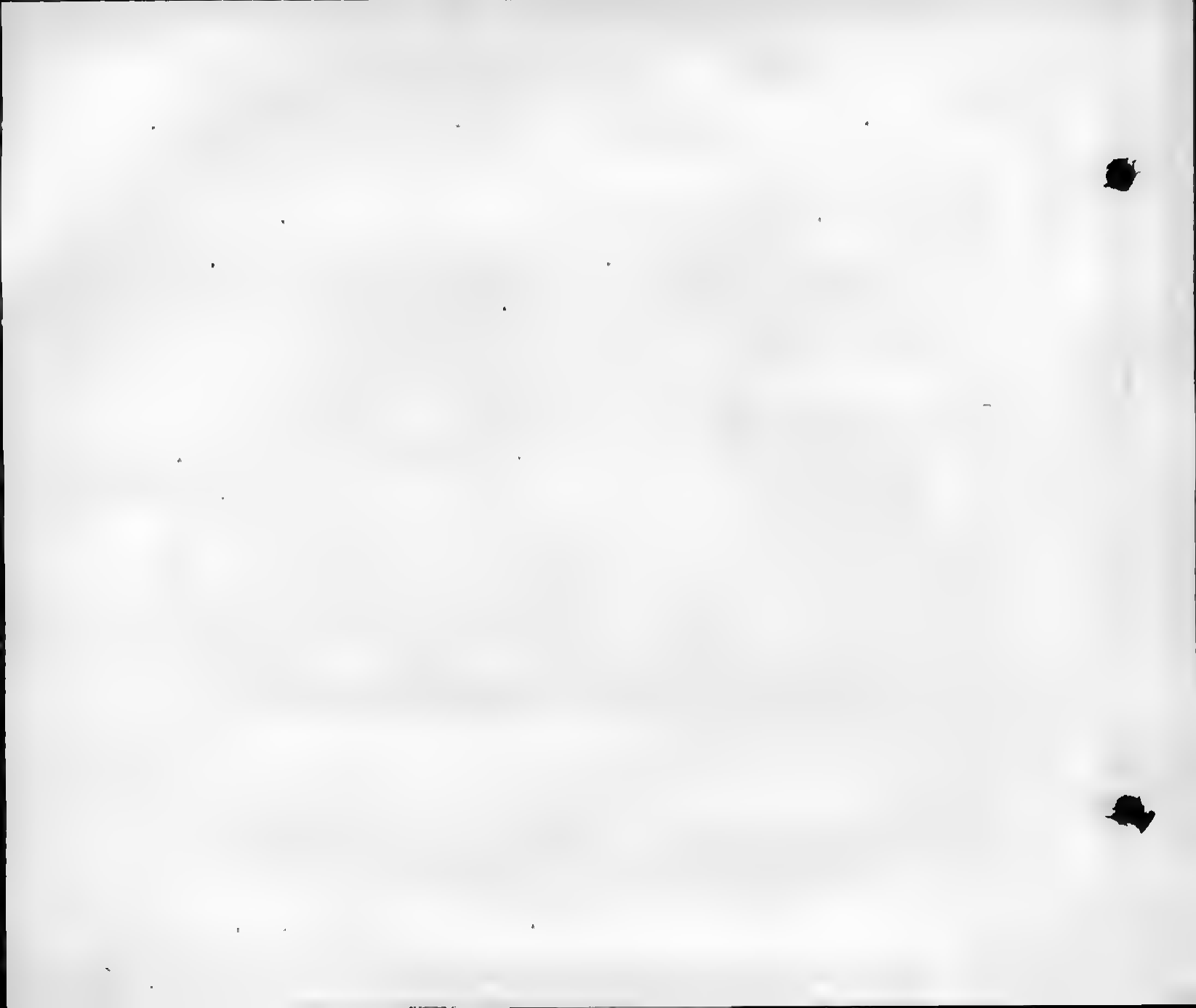
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Milford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Milford</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3608 Latham Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>PEARL</u> Middle <u>T.</u> Last <u>HART</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>21,</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1878</u>
9. AGE (In years last birthday) <u>81</u> yn		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Von Klenke</u>		14. MOTHER'S MAIDEN NAME <u>Nannie MacDonaldsen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>--</u>		16. SOCIAL SECURITY NO <u>--</u>	
17. INFORMANT <u>Mr. LeRoy Wood - 3608 Latham Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>METASTATIC CARCINOMA LUNGS-PRIMARY</u> 2.2 DUE TO <u>SITE UNDETERMINED</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>ARTERIOSCLEROTIC HEART DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 MOS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-24</u> , 1959, to <u>9-21</u> , 1959, that I last saw the deceased alive on <u>9-14</u> , 1959, and that death occurred at <u>6:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. Stanley Cohen</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>7306 Liberty Rd</u> <u>9-22-59</u> <u>Balto 7, Md</u>	
PHYSICIAN'S NAME (Type) <u>B. STANLEY COHEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cen.</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. L. ...</u>		ADDRESS <u>...</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09937

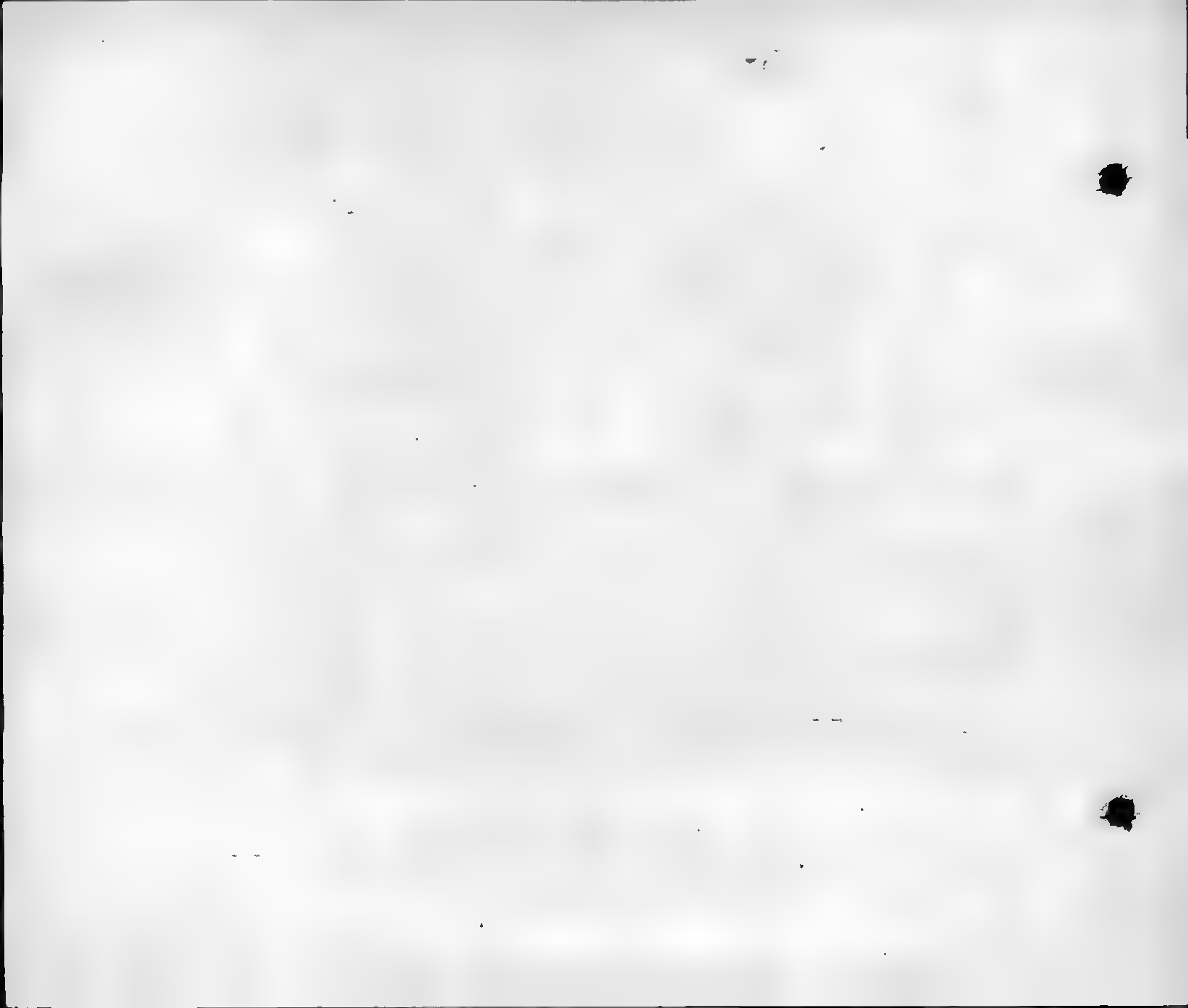
09967

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o STATE Md b. COUNTY Balto	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Balto(rural-)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (rural)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS 6108 Shadyspring	
3. NAME OF DECEASED (Type or print) Margret Ann Hawkins		4. DATE OF DEATH Month Sept Day 4 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 Mar 55
9. AGE (in years, long birthday) 4 yrs.		10. IF UNDER 1 YEAR Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Hawkins		14. MOTHER'S MAIDEN NAME Alice BAUBLITZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT Alice Hawkins(mother) same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Crushed Skull with Extrusion of Brain			
812X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Skull crushed by rear wheel of truck	
20c. TIME OF INJURY Month, Day, Year 4:50 p.m. 9-4-59	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street	20f. (City or town) (County) (State) Balto(rural) Balto MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John C. Hyle		DATE SIGNED 9-4-59	
EXAMINER'S NAME (Type) John C. Hyle MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Spec. by)	22b. DATE THEREOF 9-5-59	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	22d. LOCATION (City, town, or county) (State) Baltimore, Md
23. FUNERAL DIRECTOR'S SIGNATURE Philip E. Crach		24. REC'D BY REGISTRAR DATE SEP 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
09968
CERTIFICATE OF DEATH

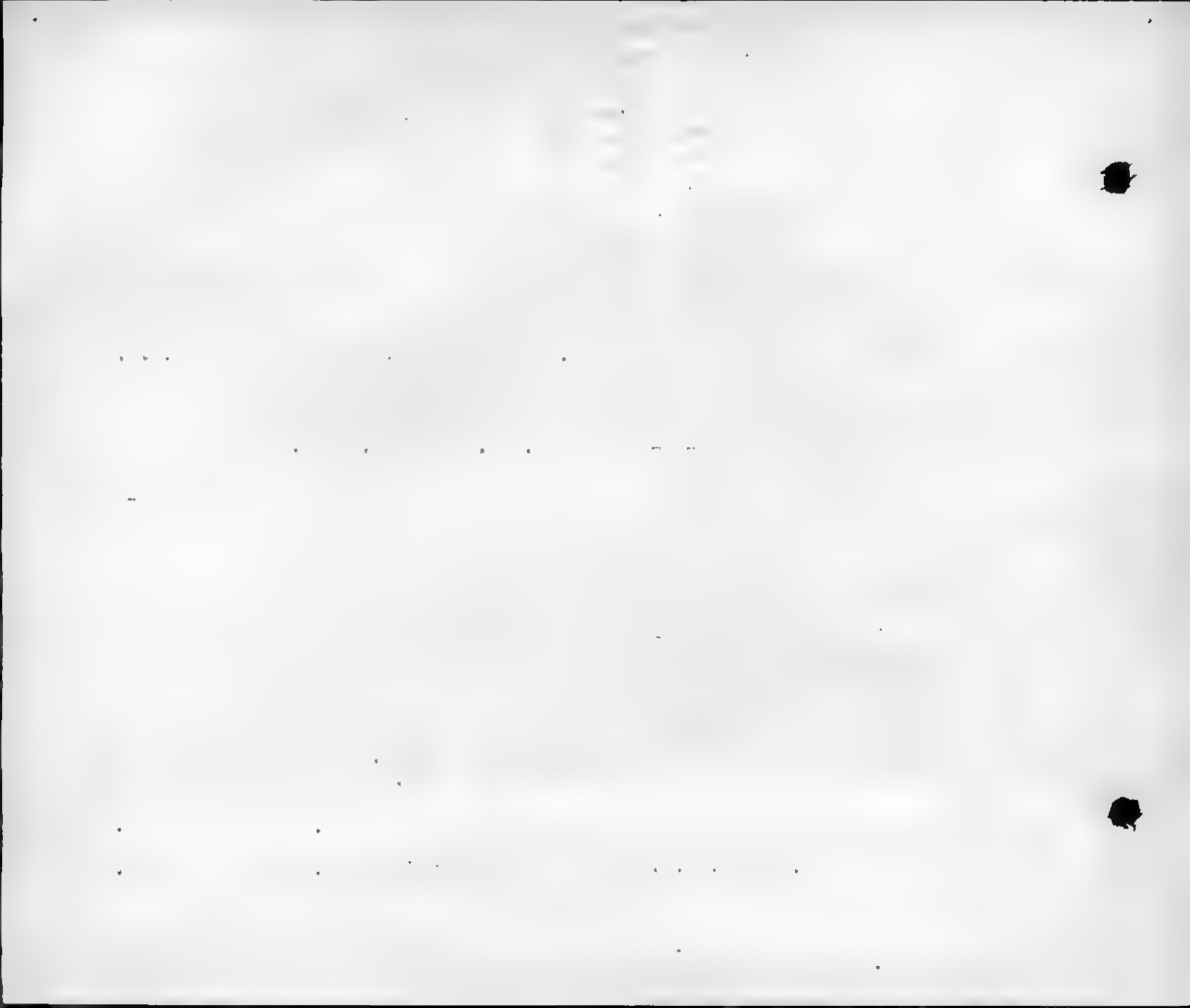
09940

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 19 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 804 Edmondson Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOCKWOOD Middle Last HENSON				4. DATE OF DEATH Month September Day 5 Year 19 59			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/25/95	
9. AGE (In years last birthday) 63 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY Ward Baking Co.		11. BIRTHPLACE (State or foreign country) Cambridge, Maryland	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Henson				14. MOTHER'S MAIDEN NAME Harriet Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 215-09-1686		17. INFORMANT Clin. Rec. VAH, Balto. 18, Md. Fort Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) PULMONARY INFARCTION 465 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DESTRUCTIVE LESION T5 - T6							INTERVAL BETWEEN ONSET AND DEATH 5 - 6 HOURS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 17, 1959 to Sept. 5, 1959 March 11, 1959 and that death occurred at 3:15 P. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Arthur T. Faulk, M.D.				M.D. VAH, BALTO 18, MD. FORT HOWARD DIV. 9/5/59			
PHYSICIAN'S NAME (Type) ARTHUR T. FAULK, M.D.				VAH, BALTO 18, MD. FORT HOWARD DIV.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-10-59		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Randolph J. Collick				ADDRESS 1214 E. Preston Street Baltimore, Maryland		24a. REC'D BY REGISTRAR DATE SEP 9 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kinn			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 of the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



09969

CERTIFICATE OF DEATH

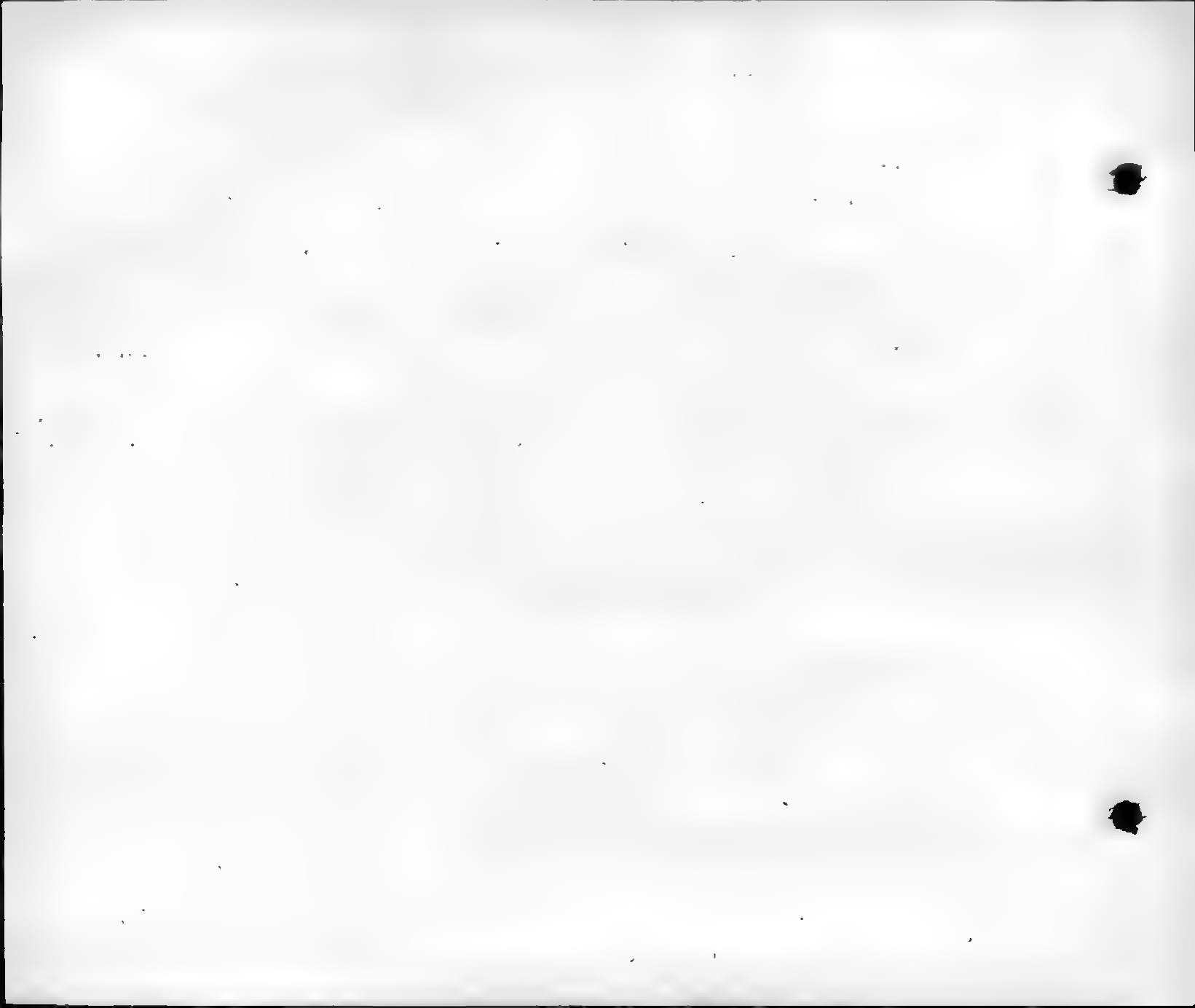
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 2 8		c. LENGTH OF STAY IN 1b 2 Mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Haven Nursing Home		e. STREET ADDRESS 25 E. Courtland Street	
3. NAME OF DECEASED (Type or print) First EVELYN Middle VIRGINIA Last HILL		4. DATE OF DEATH Month September Day 23 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH February 24, 1881
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min.	11. IF UNDER 24 HRS Months 78 Days 78 Hours 78 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Forsythe		14. MOTHER'S MAIDEN NAME Virginia ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
INFORMANT Mrs. Earl M. France		Address 932 Bardswell Rd. Balto. 28	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ART PRINSELENTIC CARDI - URSCHIAN 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DISEASE - PULMONARY EDEMA - DUE TO (c) CHRONIC DIPHTHERIA - CA COLIN ?		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/1 , 1959, to 9/23 , 1959, that I last saw the deceased alive on 9/23 , 1959, and that death occurred at 7:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Shaw M.D.		ADDRESS (Street, city or town, state) 5820 E. BROADWAY AVE DATE SIGNED 9/25/59	
PHYSICIAN'S NAME (Type) JOHN H. SHAW M.D.		BALTO. 28, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 26, 1959	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Meth. Cemetery	22d. LOCATION (City, town, or county) (State) Fountain Green, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons, Catonsville, 28, Md.		24a. REC'D BY REGISTRAR SEP 28 '59	24b. REGISTRAR'S SIGNATURE Arthur S. France

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09941

09970

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE Maryland 7 b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMMA FLORENCE HOBBS		4. DATE OF DEATH Month September Day 11 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 83 yrs.
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Benjamin J. Hobbs		14. MOTHER'S MAIDEN NAME Catherine Warthon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Albert Migan 8615 Liberty Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery occlusion (c) Arterio-sclerosis			INTERVAL BETWEEN ONSET AND DEATH 5 mts
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1950 to Sept 10, 1959 , that I last saw the deceased alive on Sept 10, 1959 , and that death occurred at 2:40 p.m. from the causes and on the date stated above ADDRESS (Street, city or town, state) Pikesville, Md. DATE SIGNED 9/14/59			
ACTUAL SIGNATURE Louis Dalman		M.D. Medical Center, Pikesville 814	
PHYSICIAN'S NAME (Type) GEORGE RAMAPURAN		Pikesville Medical Center Pikesville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-16-59	22c. NAME OF CEMETERY OR CREMATORY Montevista Cemetery	22d. LOCATION (City, town, or county) (State) Johnson City, Tenn.
23. FUNERAL DIRECTOR'S NAME ELLSWORTH ARMACOST		24a. REC'D BY REGISTRAR SEP 15 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Kinn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



09971

CERTIFICATE OF DEATH

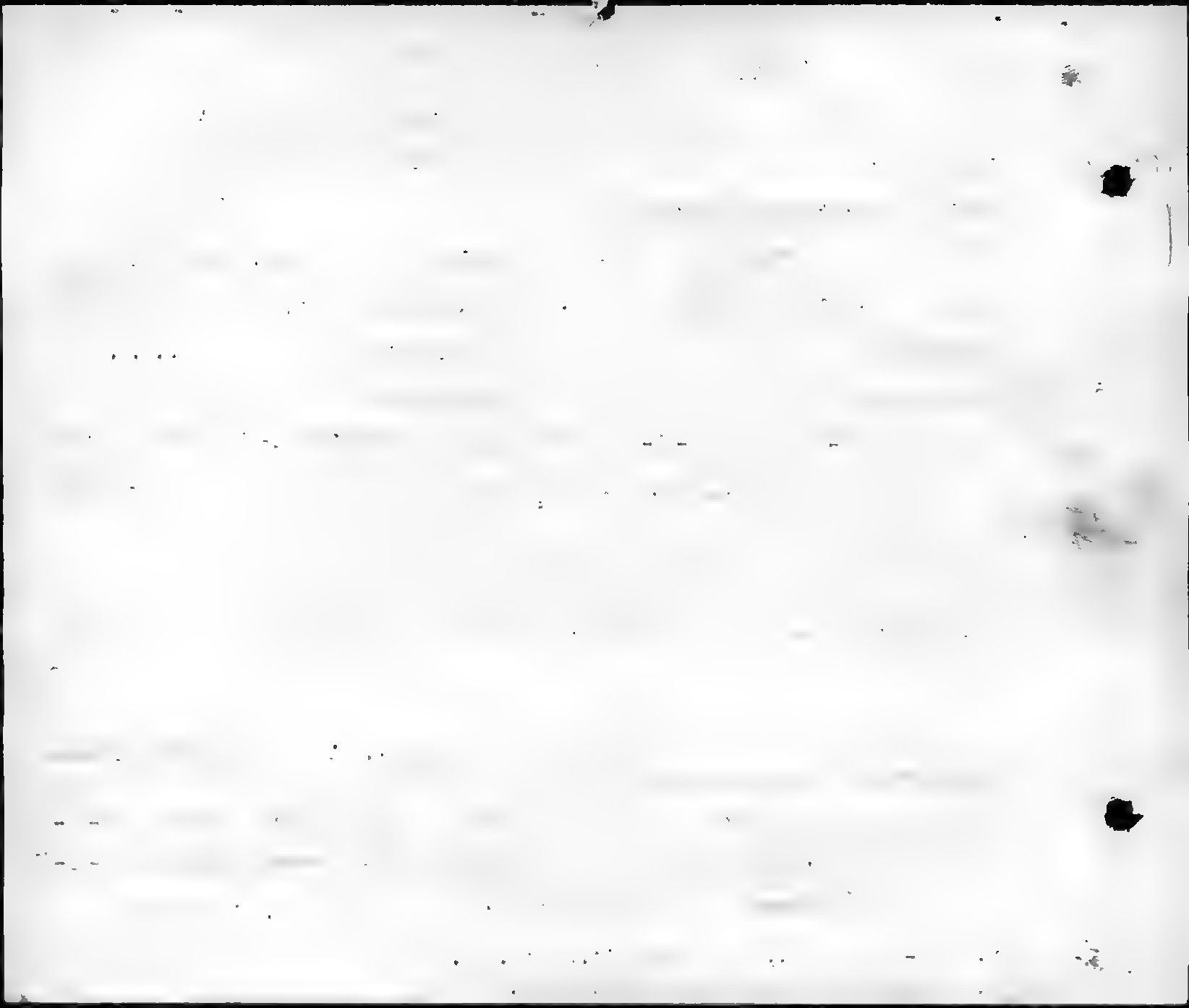
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY Talbot ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TILGHMAN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle - - Last HOLLER		4. DATE OF DEATH Month SEPTEMBER Day 11 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JUNE 3, 1892
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY PENNSYLVANIA	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALFRED HOLLER		14. MOTHER'S MAIDEN NAME ELLEN SWARTZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 206-03-4894	
17. INFORMANT CLIN REC		Address VAH BALTIMORE MD- FT HOWARD DIVISION	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG, RIGHT 165X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) ADHESIVE PERICARDITIS; CHRONIC PASSIVE CONGESTION OF LIVER		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from 5-14-59 , 19____, to Sept. 11 , 19 59 and that death occurred on 11:35 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John D. Talbert		DATE SIGNED 9-13-59	
PHYSICIAN'S NAME (Type) JOHN D. TALBERT		DATE SIGNED 9-13-59	
22a. BURIAL, CREMATION, REMOVAL Removal	22b. DATE THEREOF 9-14-59	22c. NAME OF CEMETERY OR CREMATORY MAYSVILLE CEMETERY	22d. LOCATION (City, town, or county) (State) MAYSVILLE, PENNSYLVANIA
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Inc., 6009 Harford Rd., Balto., Md.		24a. REC'D BY REGISTRAR SEP 15 '59	24b. REGISTRAR'S SIGNATURE Arthur G. Funn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SHIP TO: BAIRD FUNERAL HOME, GREENVILLE, PENNA.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

19943

09972

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut an Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Parkton</i>		c. LENGTH OF STAY IN 1b <i>Rural-Parkton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hereford</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John H. Hoover, Jr.</i>		4. DATE OF DEATH <i>September 25, 1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 11, 1891</i>
9. AGE (In years last birthday) <i>68</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Service St. Operator Service Station Balto. Co., Md.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U. S. A.</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Adam Hoover</i>		14. MOTHER'S MAIDEN NAME <i>Francis Esterline</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO <i>41-2419-248-22-0489</i>	
17. ADDRESS <i>Adm. Hoover, Parkton Md. R.D.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Cardiac Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>after five</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 24</i> , 1959, to <i>Sept 25</i> , 1959, that I last saw the deceased alive on <i>Sept 25</i> , 1959, and that death occurred at <i>8:15 A.M.</i> from the causes and on the date stated above			
ACTUAL SIGNATURE <i>Milner Bortner</i> M.D.		ADDRESS (street, city or town, state) <i>White Hall, Md.</i> DATE SIGNED <i>9/26/59</i>	
PHYSICIAN'S NAME (Type) <i>Milner Bortner</i>		<i>White Hall Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept 28, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Hereford Baptist Cem</i>		22d. LOCATION (city, town, or county) (State) <i>Parkton, Md. R.D.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jacob Hartenstein</i> ADDRESS <i>New Freedom, Pa</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 30 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Hines</i>	

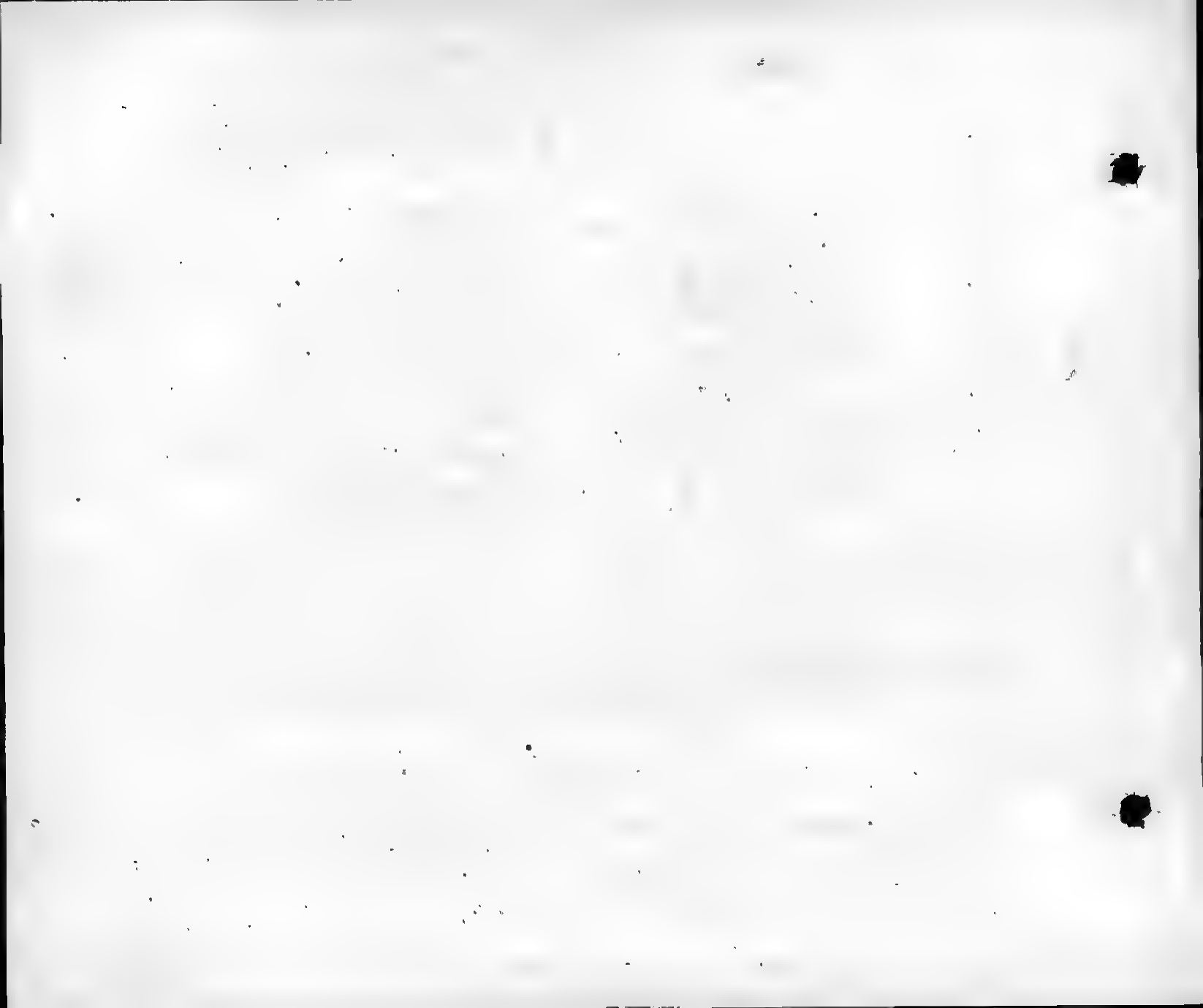
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



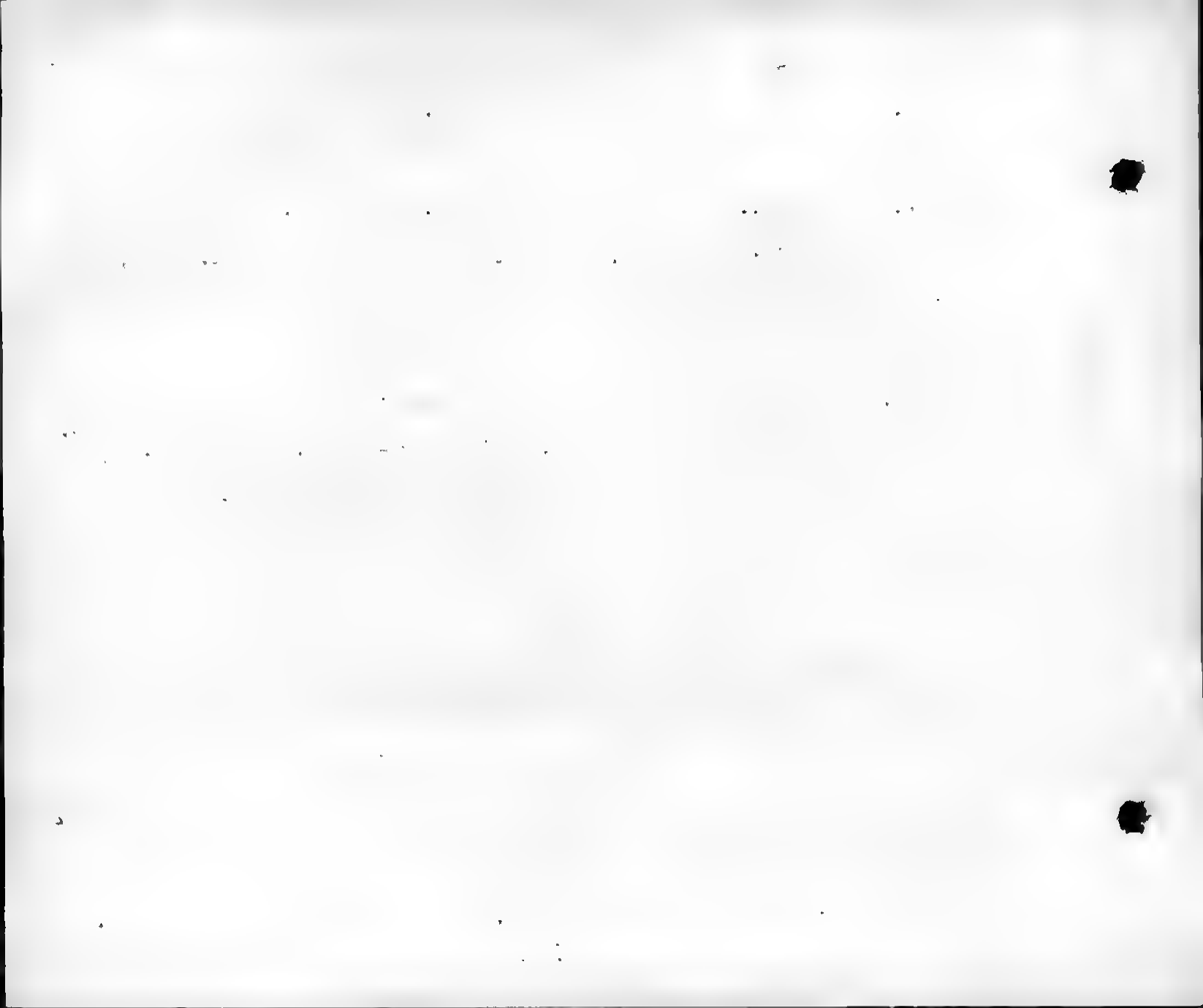
09973

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>		c. LENGTH OF STAY IN 1b <u>24.14</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>229 W. Timonium Rd.</u>		d. STREET ADDRESS <u>1719 N. Calvert St.</u>	
3. NAME OF DECEASED (Type or print) First <u>LOUISE</u> Middle <u>L.</u> Last <u>HOUGHTON</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>2</u> Year <u>19 59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25, 1870</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife (rtd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John L. Ringwalt</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Elder</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>H. R. Houghton - 229 W. Timonium Rd.</u>		Address <u>Timonium, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>422.1 Arteriosclerotic Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>_____</u> DUE TO (c) <u>_____</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>_____</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 30, 1959</u> to <u>Sept. 2, 1959</u> , that I last saw the deceased alive on <u>August 30th</u> , 19 <u>59</u> , and that death occurred at <u>2:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. K. Quinn</u>		ADDRESS (Street, city or town, state) <u>1927 York Rd, Timonium</u> DATE SIGNED <u>9/4/59</u>	
PHYSICIAN'S NAME (Type) <u>_____</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Vickner & Sons - Balto.</u>		24a. REC'D BY REGISTRAR <u>DA SEP 8 '59</u>	
ADDRESS <u>171 Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

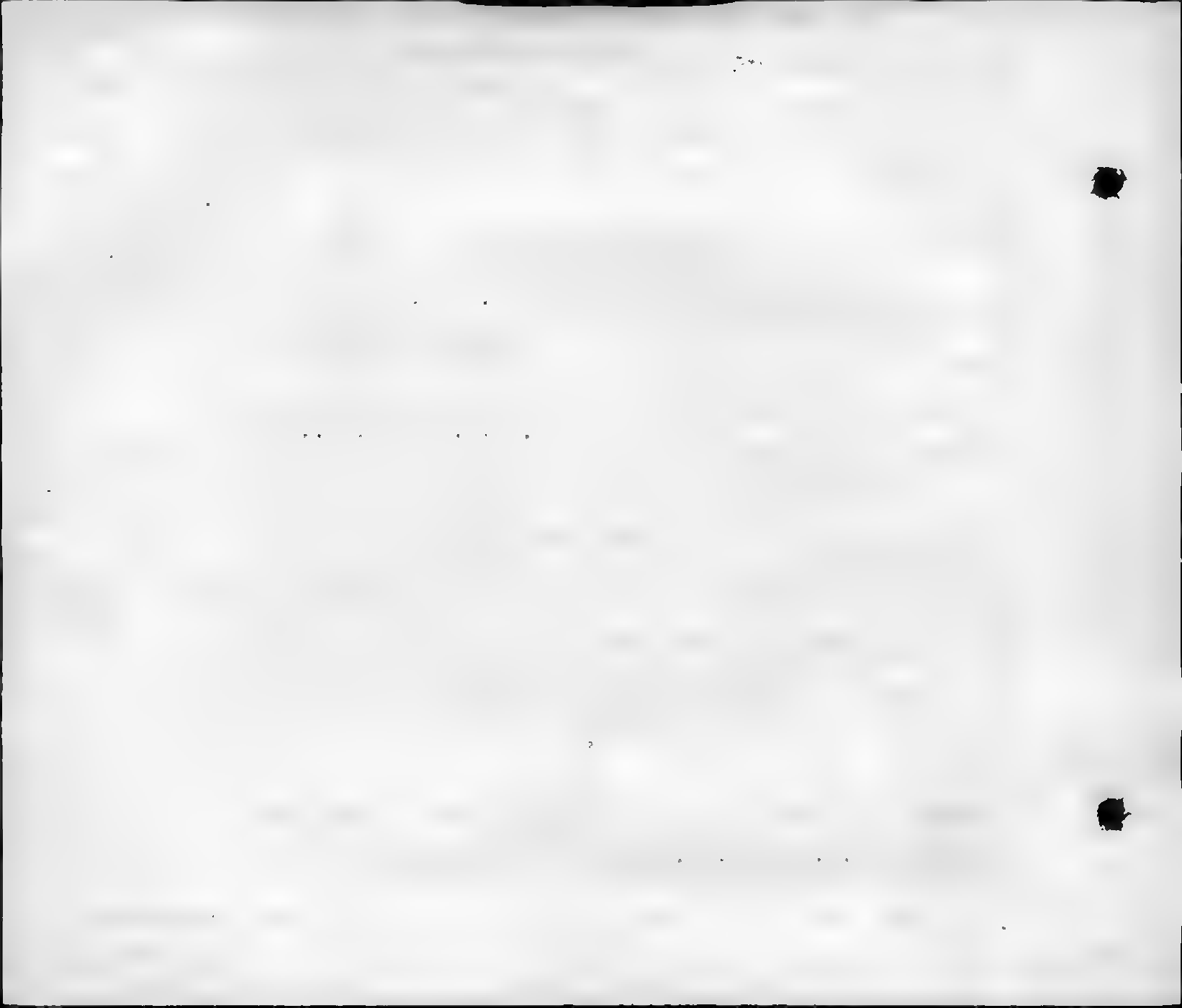
09945

09897

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3001 Dunglew Road				d. STREET ADDRESS 131 South East Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EDNA ESTELLE JAMISON				4. DATE OF DEATH Month Day Year September 23, 1959			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 31st, 1882	9. AGE (In years last birthday) 76 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Julius Wood				14. MOTHER'S MAIDEN NAME Ida Ortlip			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. W.F. Hoover, Jr.,		Address Same as #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 100.8 DUE TO Carcinoma of colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 12 months 6 months							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 1959 , to 9-22-1959 , that I last saw the deceased alive on 9-22- , 19 59 , and that death occurred at 12:20A from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2900 Dunran Road DATE SIGNED 9/24/59							
ACTUAL SIGNATURE B.W. Sollod M.D.				Baltimore 22, Maryland			
PHYSICIAN'S NAME (Type) B.W. Sollod, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/59		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter P. Brooks & Bradley Inc.				24a. REC'D BY REGISTRAR DATE SEP 28 '59		24b. REGISTRAR'S SIGNATURE Carlton L. Thomas	



09974

CERTIFICATE OF DEATH

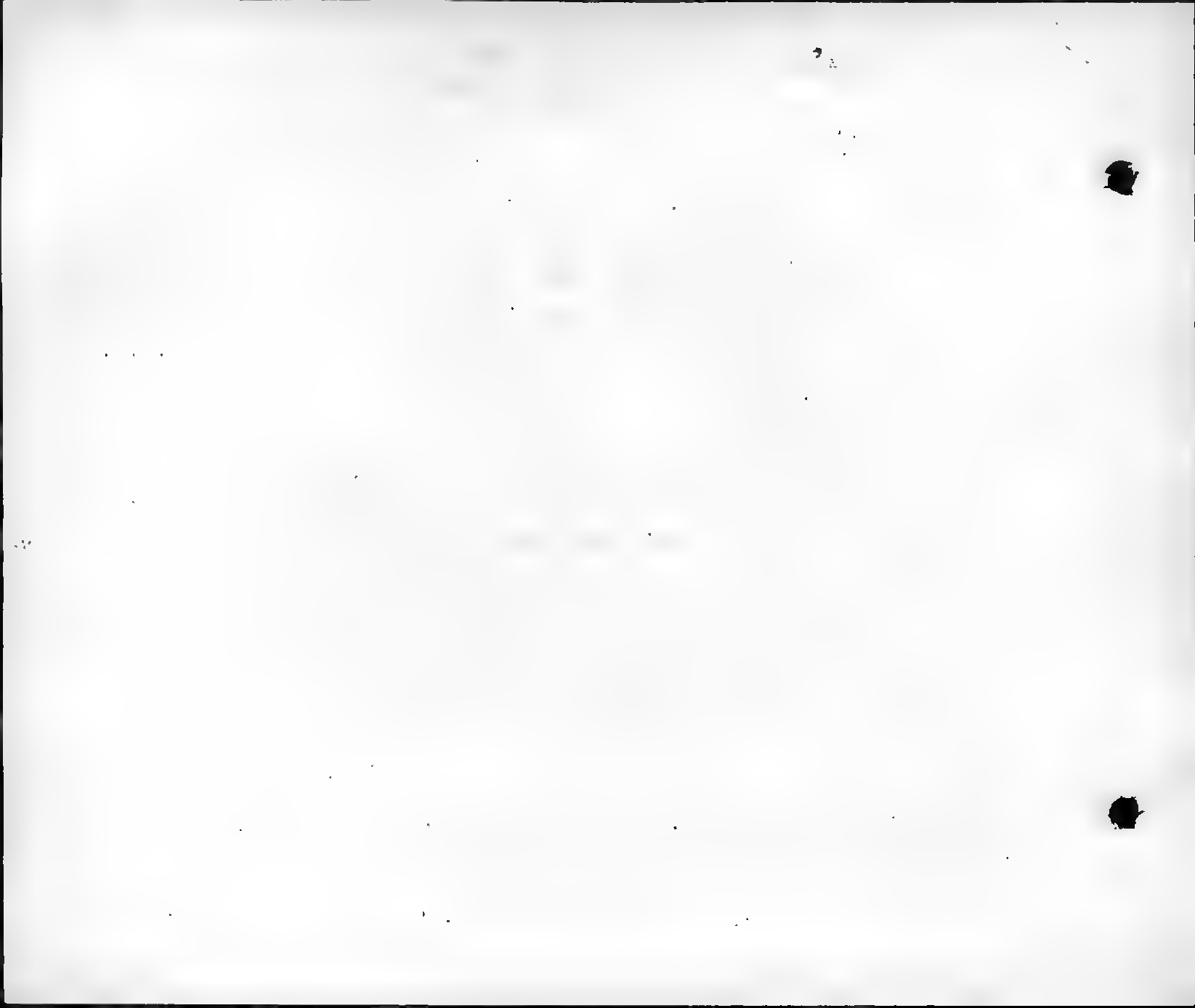
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRACELAND PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRACELAND PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6713 GRACELAND AVENUE		d. STREET ADDRESS 6713 GRACELAND AVENUE	
3. NAME OF DECEASED (Type or print) ALICE L. JENKINS		4. DATE OF DEATH SEPTEMBER 12, 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 21, 1879
9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE LAWTON		14. MOTHER'S MAIDEN NAME RHODA CHARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. YES	
INFORMANT MRS EURITH HARMON		Address (SAME)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro-Vascular disease 472.1 DUE TO Arteriosclerotic Cardio Vasculardisease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) 2 yrs (c)			INTERVAL BETWEEN ONSET AND DEATH 1 wk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 1, 1959 to Sept 12, 1959 that I last saw the deceased alive on Sept 12, 1959 , and that death occurred at 2:35 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Baumgardner		ADDRESS (Street, city or town, state) Baltimore Md	
PHYSICIAN'S NAME (Type) HE		DATE SIGNED 9/12/59	
22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/15/59	22c. NAME OF CEMETERY OR CREMATORY MAGOTHY CHURCH CEMETERY	22d. LOCATION (City, town, or county) (State) ANNA ARUNDEL COUNTY
23. FUNERAL DIRECTOR'S SIGNATURE HE		ADDRESS RY SANDER & SONS INC	
DATE BALTIMORE 13, MARYLAND		24a. REC'D BY REGISTRAR DATE SEP 15 '59	24b. REGISTRAR'S SIGNATURE C. L. & K. H. H.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VS A15 (4)
15M 9/58



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 48 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09975 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09947

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton				c. LENGTH OF STAY IN 1b —			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) L' Hirondelle Club				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edgar Middle D. Last Johnson				4. DATE OF DEATH Month Sept. Day 12 Year 1959			
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 25, 1899	
9. AGE (In years, last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CATERER & HELPER AIRPLANE FACTORY				10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE, MD			
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Armond Johnson				14. MOTHER'S MAIDEN NAME LEANNA COLEMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 216-05-4696			
17. INFORMANT ANN D. JOHNSON				Address 3316 Leighton Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1/16 DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 0 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 9/16/59		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	
22d. LOCATION (City, town, or county) BALTIMORE MD				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lynch				ADDRESS 3463 Druid Hill		24a. REC'D BY REGISTRAR SEP 15 59	
24b. REGISTRAR'S SIGNATURE C. J. Lynch				DATE			

MEDICAL CERTIFICATION

DATE SIGNED

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09976

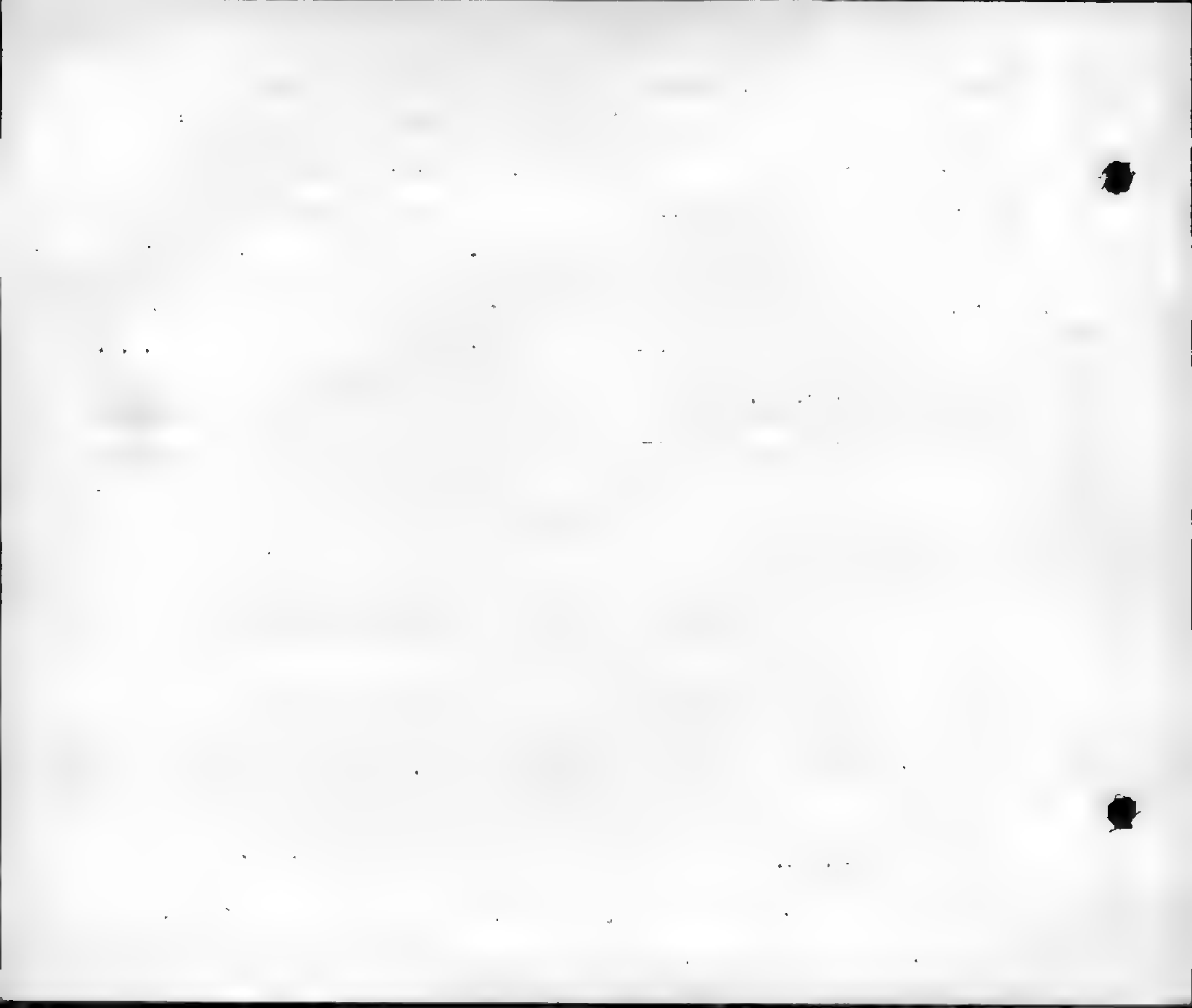
CERTIFICATE OF DEATH

Reg. Dist. No.

09948

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland c. LENGTH OF STAY IN 1b 2 months d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland d. STREET ADDRESS 3702 Hamilton Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cheryl Middle Lynn Last Jones		4. DATE OF DEATH Month 9 Day 18 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/24/59
9. AGE (In years last birthday) yrs 5		IF UNDER 1 YEAR Months 5 Days 19	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ernest Lee Jones, Sr.	
14. MOTHER'S MAIDEN NAME Sarah Ann Jones		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO no		INFORMANT Rosewood Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchitis - pneumonia DUE TO (b) Acute Bronchitis & asperatione DUE TO (c) pneumonia CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. Two days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hydrocephalus and Cerebral Arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE (IN WORDS) THE OCCURRENCE, nature of injury in Part I or Part II of item 18 (none)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 Sept 1959 to 18 Sept 1959 that I last saw the deceased alive on 18 Sept 1959 and that death occurred at 1:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry G. Butler M.D.		ADDRESS (Street, city or town, state) Owings Mills, Md. DATE SIGNED 18 Sept 59	
PHYSICIAN'S NAME (Type) Harry G. Butler			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 9/19/59	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR SEP 21 '59 DATE 24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

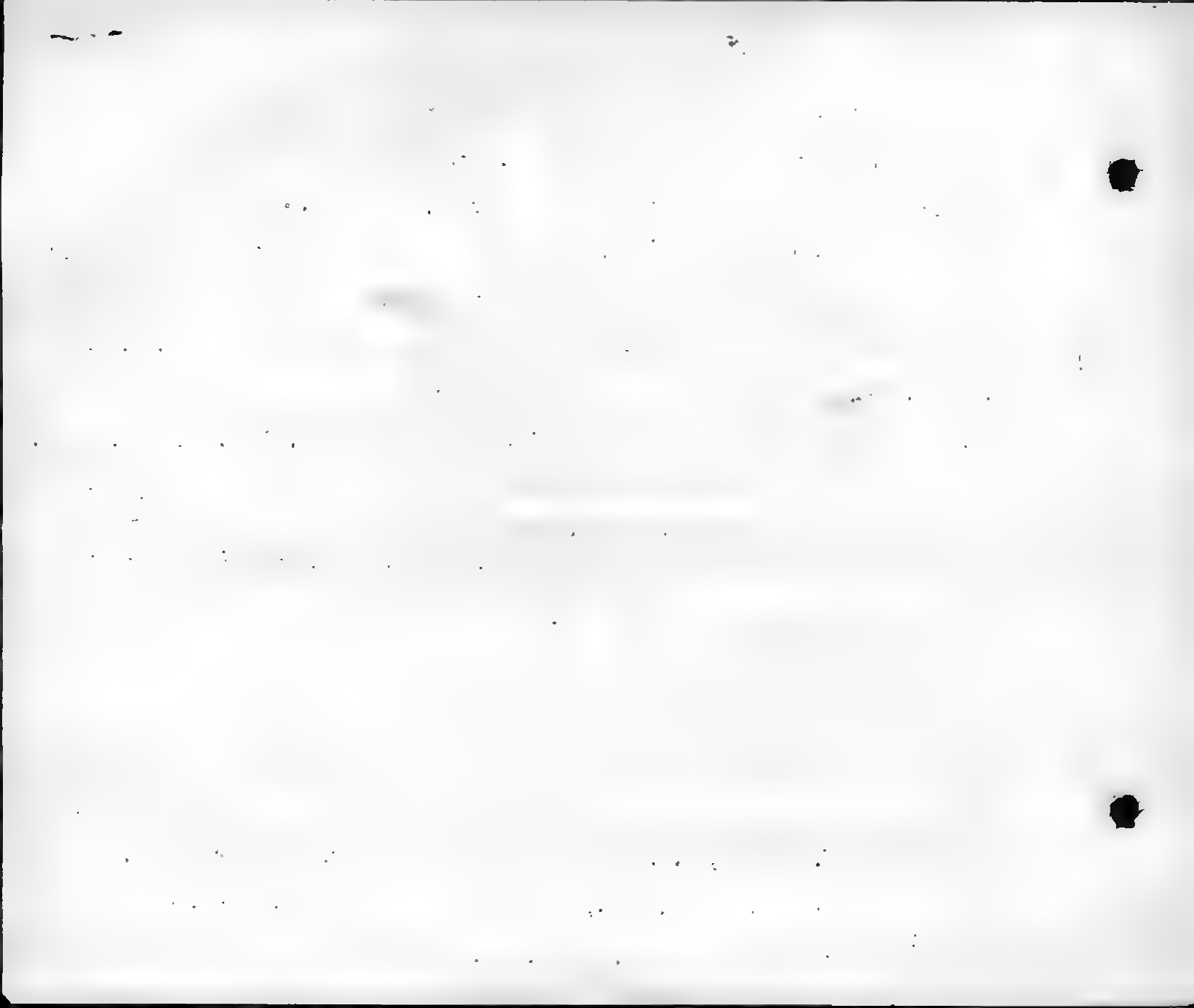
09977

CERTIFICATE OF DEATH

Reg. Dist. No.

(5949)

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY in 1b 1 33 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore(17) c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 3001 4 d. STREET ADDRESS 1708 N. Mount Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First THOMAS Middle E. Last JONES		4. DATE OF DEATH Month September Day 20 Year 1959	
5 SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 16, 1899
9. AGE (in years last birthday) 60 yrs		10. IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lka Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel B. Jones		14. MOTHER'S MAIDEN NAME Ida Gould	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 213-21-1144	
17. INFORMANT Olin. Records, VAH, Balto. 18, Md., Fort Howard Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.6 INTESTINAL OBSTRUCTION DUE TO ADENOCARCINOMA, COLON Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. RECENT METASTATIC ADENOCARCINOMA, LIVER & URINARY BLADDER (b) UNKNOWN (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY CONGESTION AND EDEMA- RECENT		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 9/21/59			
ACTUAL SIGNATURE _____ M.D.			
PHYSICIAN'S NAME (Type) DAVID A. CURTIS, M.D.		VAH, BALTO 18, MD. FORT HOWARD DIV.	
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	22b. DATE THEREOF 9-25-59	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE George Kelson ADDRESS George Kelson Funeral Home, 1348 N. Calhoun St. Balto 17, Md.		24a. REC'D BY REGISTRAR SEP 23 '59 24b. REGISTRAR'S SIGNATURE Curtis & Thompson	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09978

CERTIFICATE OF DEATH

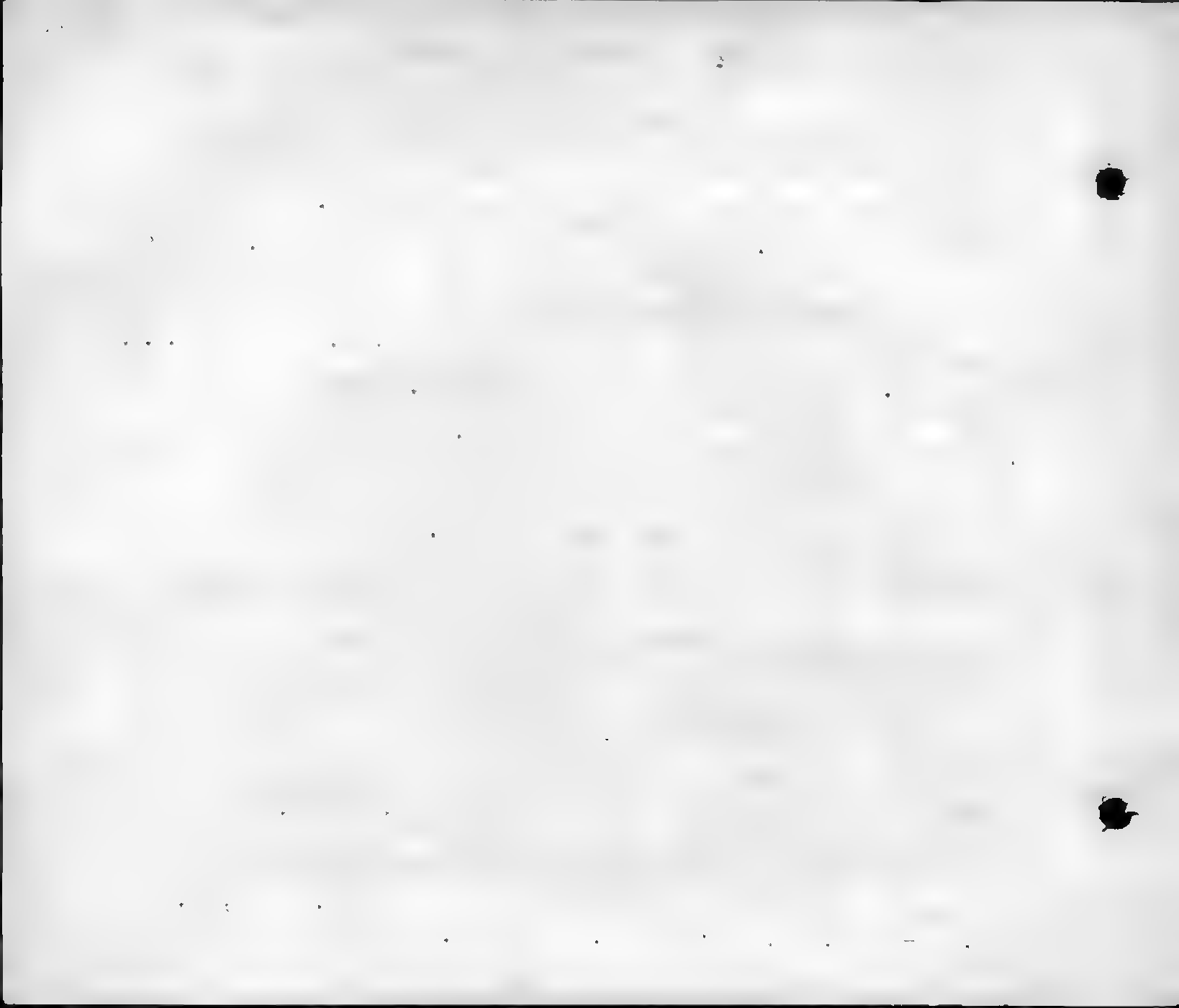
Reg. Dist. No.

09950

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore County				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6408 Sherwood Road				d. STREET ADDRESS 6408 Sherwood Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Lillian M. Middle Kahl Last				4. DATE OF DEATH Month Sept. Day 25 Year 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/16/1892	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. Gerlach				14. MOTHER'S MAIDEN NAME Agnes G. Rafferty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Arthur G. Kahl, 6408 Sherwood Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. Acute Coronary Occlusion 4 hours. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis. 2 years DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from 5-6-57 , 19 57 , to 9-25-59 , 19 59 , that I last saw the deceased alive on 9-25-59 , 19 59 , and that death occurred at 4-15 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1114 St. Paul St. DATE SIGNED							
ACTUAL SIGNATURE <i>[Signature]</i> M.D.				DATE SIGNED 1114 St. Paul St.			
PHYSICIAN'S NAME (Type) Baltimore 2 Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/28/59	22c. NAME OF CEMETERY OR CREMATORY Moreland Park		22d. LOCATION (City, town, or county) (State) Balto. County, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Rd., Towson 4, Md.				24a. REC'D BY REGISTRAR DATE SEP 28 '59		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 248 9-11-59 et

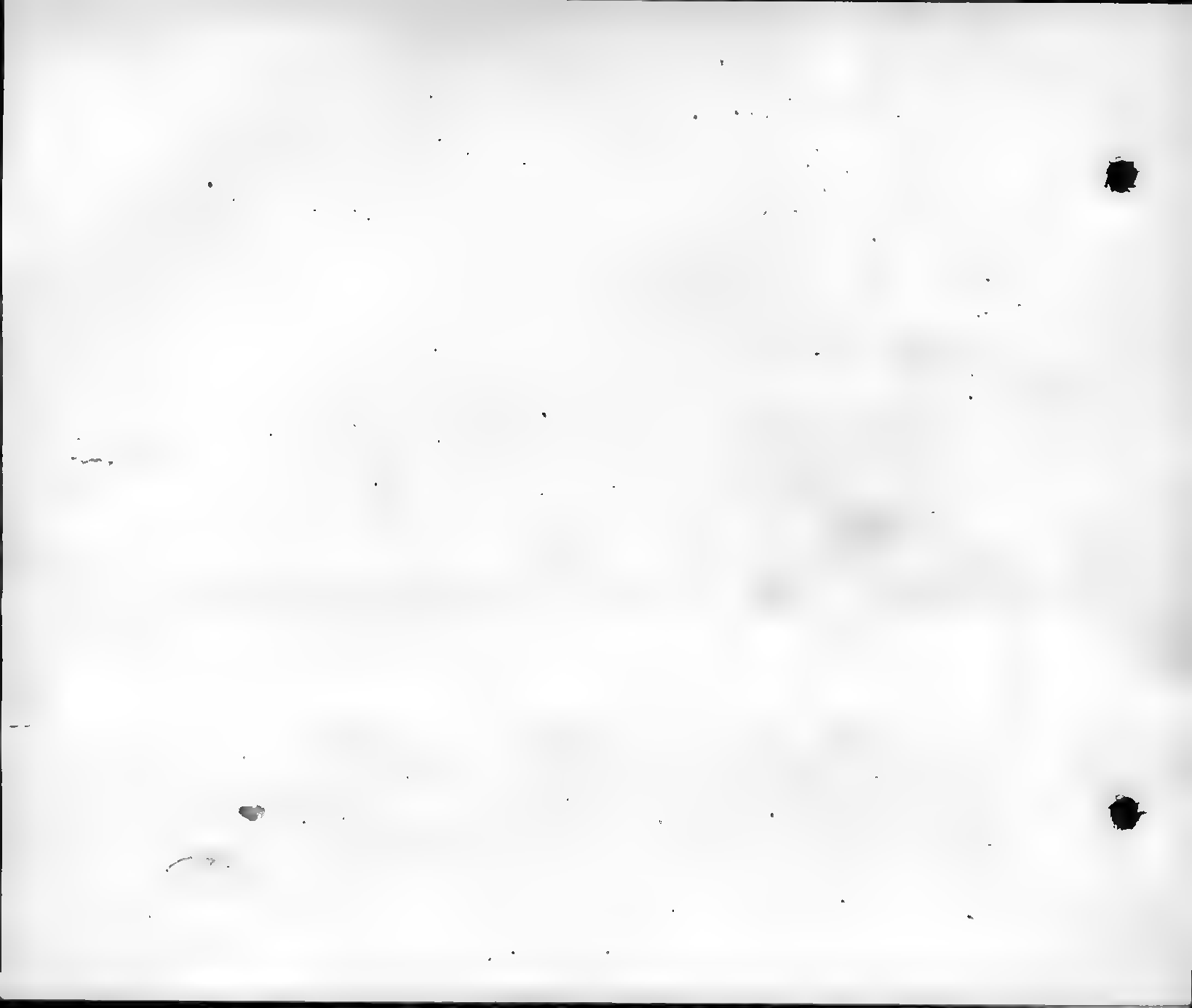
09979

CERTIFICATE OF DEATH

09951

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>133 Shade Ave</u>				d. STREET ADDRESS <u>2509 Elmore Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Mammie</u> First <u>Kahn</u> Middle Last				4. DATE OF DEATH Month <u>9-</u> Day <u>8-</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>62</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Isaac</u>				14. MOTHER'S MAIDEN NAME <u>Thelma</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
INFORMANT <u>Isadore Kahn - Acme</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma</u> <u>177.2</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>9 mos</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July</u> 19 <u>59</u> to <u>Sept</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 7</u> 19 <u>59</u> , and that death occurred at <u>3:30</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3600 Lochearn Dr.</u> DATE SIGNED <u>Sept 8, 59</u>							
ACTUAL SIGNATURE <u>Walter Bakal</u> M.D.				PHYSICIAN'S NAME (Type) <u>3600 Lochearn Dr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Windsor Hill Rd</u>	
22d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Louis Inc - 2100 Eutaw Place</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. K...</u>	



09980
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 57 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First STEPHEN Middle J Last KEBER		4. DATE OF DEATH Month SEPTEMBER Day 22 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 22 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		10b. KIND OF BUSINESS OR INDUSTRY BARBER SHOP	9. AGE (In years last birthday) 53
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WALTER KEBER		14. MOTHER'S MAIDEN NAME MARY TRUSKI	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO 219-16-8319	
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, TERMINAL DUE TO (b) BRONCHOGENIC CARCINOMA, LEFT UPPER LUNG METASTATIC CARCINOMA, PERIBRONCHIAL AND SUPRA-CLAVICULAR LYMPH NODES, LEFT ADRENAL AND BRAIN (c) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN UNKNOWN
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PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) **Surgical Absence, right testis** 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **July 27**, 19 **59**, to **September 28, 59**, and that death occurred at **3:25 P.M.**, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE *John W. Crawford* M.D.
PHYSICIAN'S NAME (Type) **JOHN W. CRAWFORD, M.D.** **VAH, BALTIMORE 18, MD, FT. HOWARD DIV. 9/23/59**

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/26/59	22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm S Fialkowski Funeral Parlor		24a. REC'D BY REG STRAR DATE SEP 24 '59	24b. REGISTRAR'S SIGNATURE C. J. H. H. H.

2007 Eastern Ave Balto 31 Md

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

22/35/11

742 *Mytilus edulis* L.

09981

CERTIFICATE OF DEATH

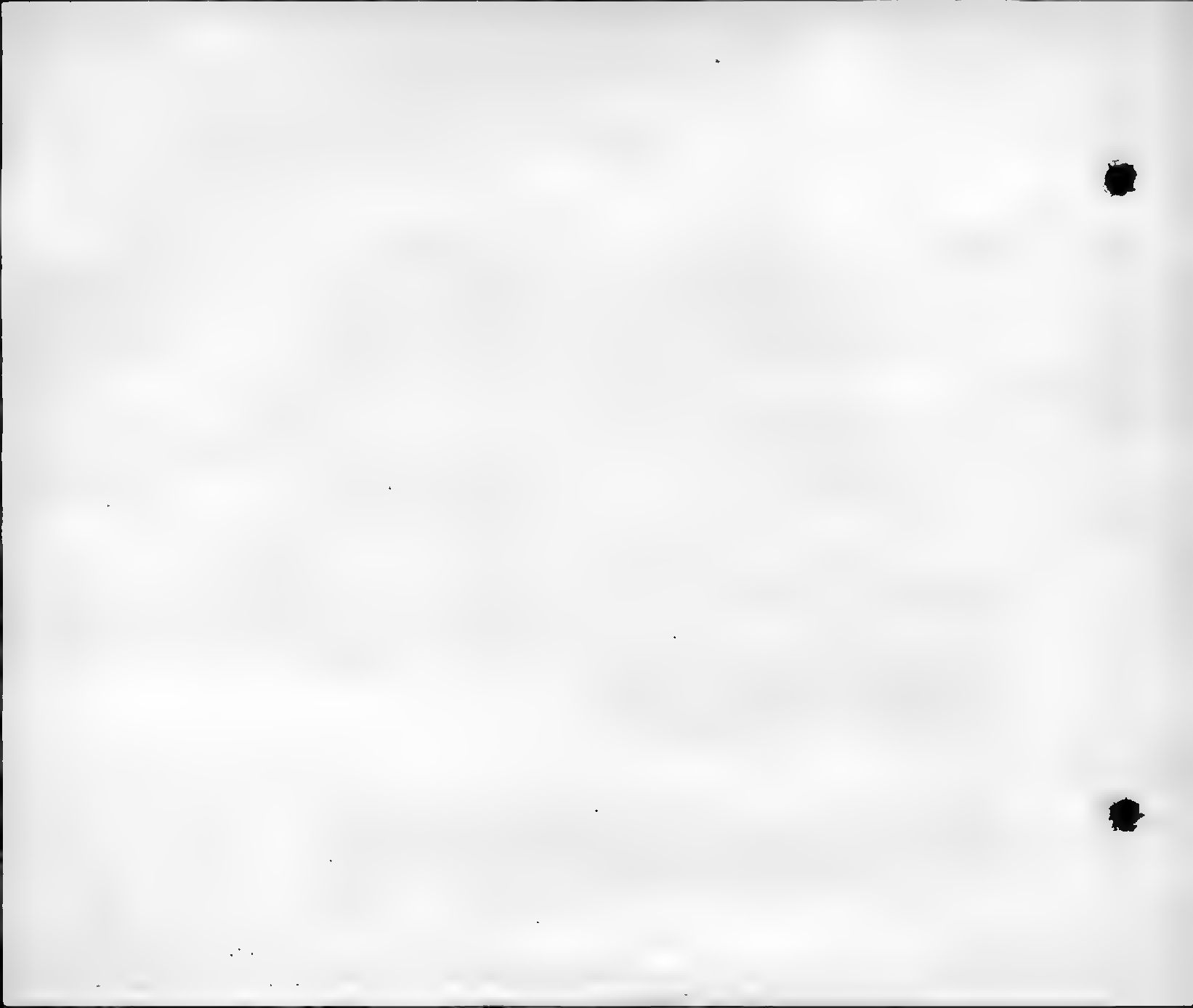
09953

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>		c. LENGTH OF STAY IN 1b <u>17mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>803 Fifth Ave.</u>		e. STREET ADDRESS <u>803 Fifth Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>W.</u> Last <u>King, Sr.</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1892</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New Bath Bath Baltimore Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>US A</u>		12. CITIZEN OF WHAT COUNTRY? <u>US A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Melvin W. Marshall</u>		Address <u>803 5th Ave. Lansdowne, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchio pneumonia</u> DUE TO <u>Chronic Bronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>sev. years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Poor Nutritional State</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>—</u> Day <u>19</u> Year <u>1959</u> Hour <u>—</u> a.m. <u>—</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 14, 1959</u> to <u>Sept. 28, 1959</u> , that I last saw the deceased alive on <u>Sept. 26, 1959</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Florian P. Nadolski</u> M.D.		ADDRESS (Street, city or town, state) <u>2703 Hannum Ave. Keyld</u>	
PHYSICIAN'S NAME (Type) <u>Florian P. Nadolski</u>		DATE SIGNED <u>9/28/59</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10/1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Ritchie Heights</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Brown</u>		ADDRESS <u>901 Solanus St.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur B. Kline</u>	
DATE <u>SEP 30 1959</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00982

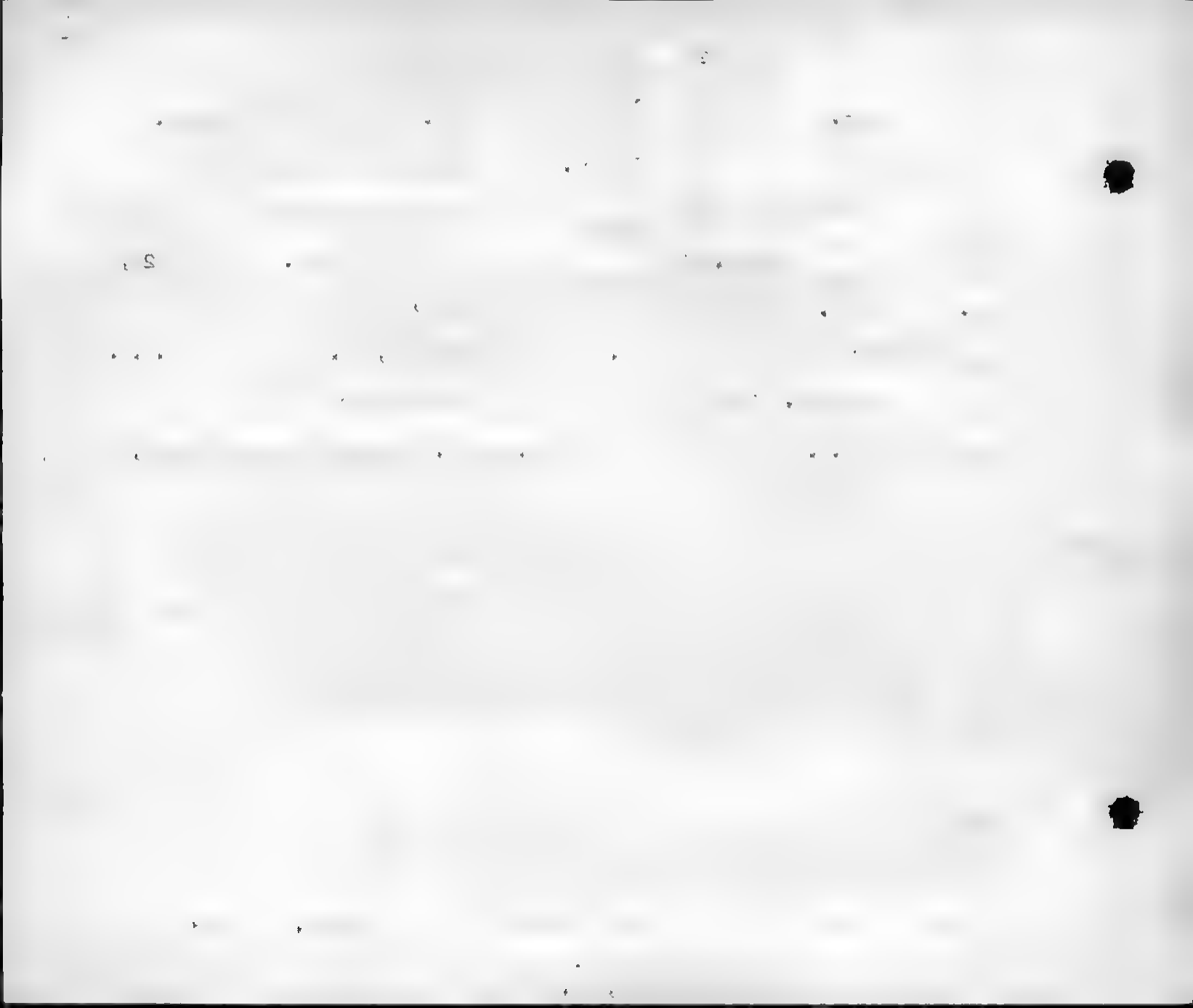
CERTIFICATE OF DEATH

09954

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale		c. LENGTH OF STAY IN 1b 15 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8004 Douglas Avenue				d. STREET ADDRESS 8004 Douglas Avenue		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Andrew C. Kirk				4. DATE OF DEATH Wed. 9		Day 23 Year 19 59	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED	8. DATE OF BIRTH January 10, 1896		9. AGE (In years last birthday) 63 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Bldg.		11. BIRTHPLACE (State or foreign country) Hebbville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew C. Kirk				14. MOTHER'S MAIDEN NAME Amelia Euler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.I.		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ada M. Kirk 8004 Douglas Avenue, Balto 7			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION - 5.2.1. X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC BRONCHITIS & BRONCHIECTASIS DUE TO (c) SEVERE, PULMONARY EDEMA						INTERVAL BETWEEN ONSET AND DEATH 1 DAY - 10 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 1 , 19 59 , to SEPT 23 , 19 59 , that I last saw the deceased alive on SEPT 23 , 19 59 , and that death occurred at 8 A. M., from the causes and on the date stated above							
ACTUAL SIGNATURE Thomas E. Wheeler		ADDRESS (Street, city or town, state) 3601 Clyman Rd - Balto 7 - 9/23/59					
PHYSICIAN'S NAME (Type) THOMAS E. WHEELER		BALTO 7 - MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 26/59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers				ADDRESS 8728 Liberty Rd.		24a. REC'D BY REGISTRAR DATE SEP 24 '59	
						24b. REGISTRAR'S SIGNATURE William B. Frank	
Randallstown, Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09983 CERTIFICATE OF DEATH

09955

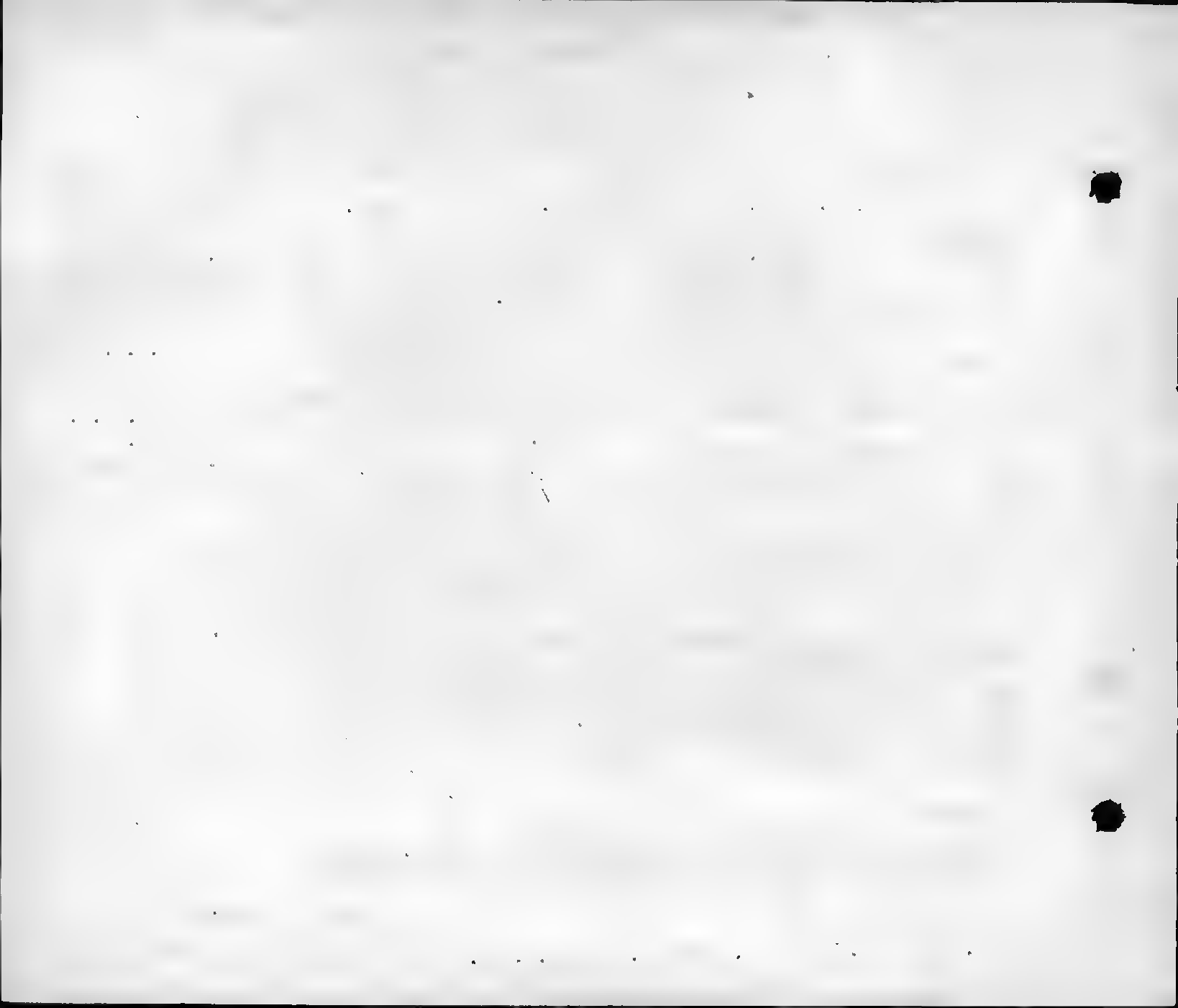
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore County				c. LENGTH OF STAY IN TB 16 months			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convl. Home, 301 Chesapeake Av.			
d. STREET ADDRESS Greenway Apts.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Samuel W. Kirk				4. DATE OF DEATH Month Day Year Sept. 21 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1871	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturing		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Kirk				14. MOTHER'S MAIDEN NAME Elizabeth Ashton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Homer Phillips, 2100 Cathedral Av., Wash., D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO Decompensative Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from April 2, 1959 to Sept 21, 1959 , that I last saw the deceased alive on Sept 21, 1959 , and that death occurred at 2 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6805 York Rd. Baltimore 12 DATE SIGNED 9/22/59 ACTUAL SIGNATURE Laurence C. Post M.D. 9/22/59 PHYSICIAN'S NAME (Type) LAURENCE C. Post							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/23/59	22c. NAME OF CEMETERY OR CREMATORY Greenmount		22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul St., Balto., Md.				24a. REC'D BY REGISTRAR SEP 23 '59		24b. REGISTRAR'S SIGNATURE Arthur A. Kneass	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

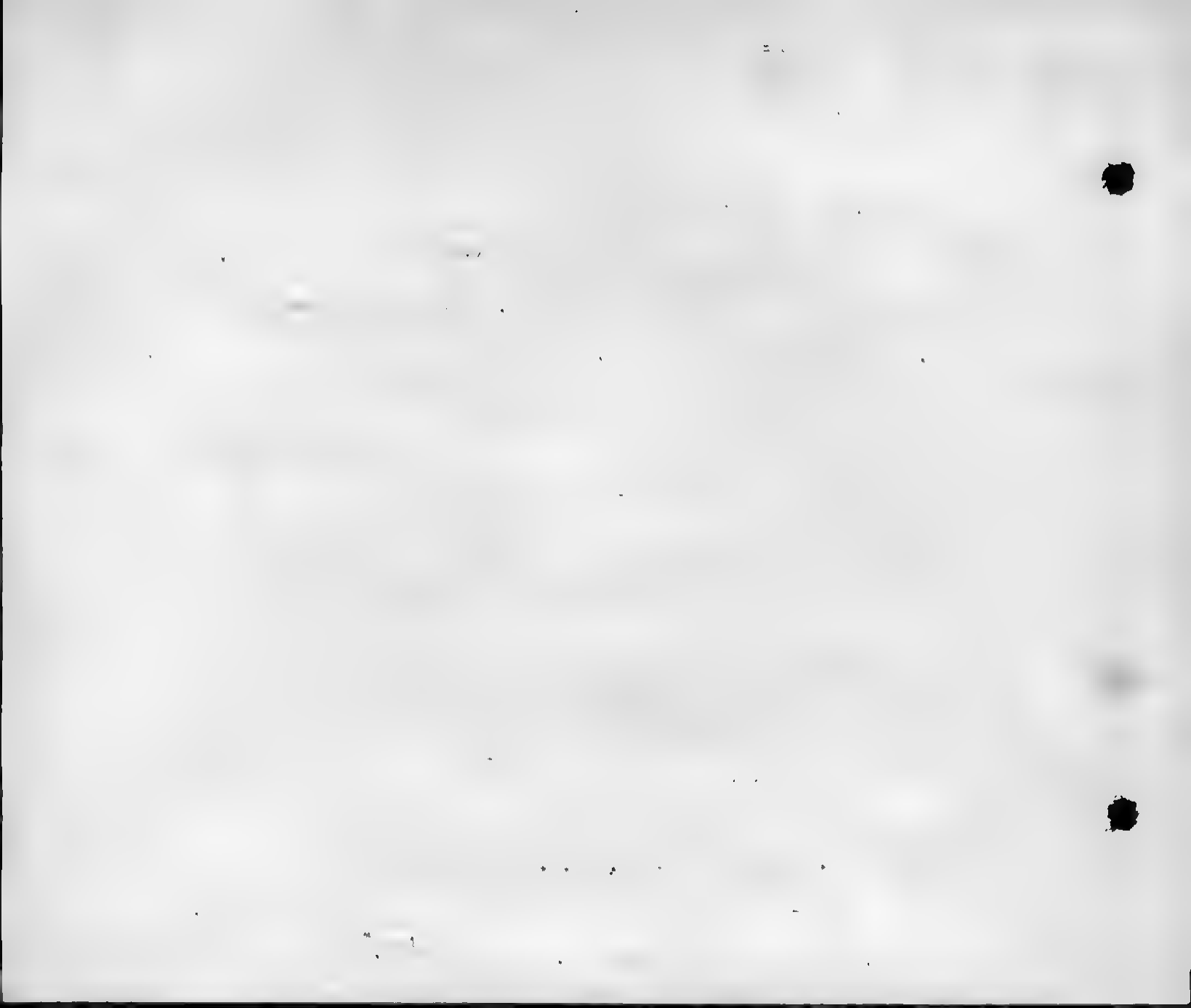
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09957

09984

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Trailer Camp, Francis Avenue		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		f. STREET ADDRESS 810 Wildwood Parkway	
3. NAME OF DECEASED (Type or print) EVANGELOS Krometis (Kromidis)		4. DATE OF DEATH Month Sept. Day 16 Year 1959		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	
8. DATE OF BIRTH Aug. 15, 1893		9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR: Months 66 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Dry Cleaning Self Emp.		10b. KIND OF BUSINESS OR INDUSTRY Turkey		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Christina ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ?	
16. SOCIAL SECURITY NO. ?		17. INFORMANT Mrs Eva Krometis		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____ PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/16/59 ACTUAL SIGNATURE W. Bradley King, Jr., M.D. EXAMINER'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9-19-59 22c. NAME OF CEMETERY OR CREMATORY Greek Cemetery 22d. LOCATION (City, town, or country) (State) Baltimore, Md. 23. FUNERAL DIRECTOR Leonard J. Ruck 5305 Harford Rd. 24a. REC'D BY REG. STRAR SEP 21 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Hines					



may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09985

CERTIFICATE OF DEATH

09958

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>401 Frederick Ave.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>	
f. STREET ADDRESS <i>401 Frederick Ave.</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Nina E. L. Leister</i>		4. DATE OF DEATH Month <i>9</i> Day <i>28</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/6/86</i>
9. AGE (In years last birthday) <i>73</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>David Roelkey</i>		14. MOTHER'S MAIDEN NAME <i>Martha Renn</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Wm. A. Leister</i>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiovascular collapse</i> DUE TO <i>Marked Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April</i> , 1950, to <i>Sept 28</i> , 1959, that I last saw the deceased alive on <i>9/28</i> , 1959, and that death occurred at <i>4:20 AM</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ramsey P. Bligh</i> M.D.		DATE SIGNED <i>9/30/59</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>9/30/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mac Nabbe + son</i>		ADDRESS <i>28</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <i>OCT 1 '59</i>		<i>John P. Hanna</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09959

09986

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived) 11 institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 13yr9mth2dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital			d. STREET ADDRESS 118 South Hanen St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Leonard Last Leonard			4. DATE OF DEATH Month September Day 5 Year 1959		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1868	9. AGE (In years last birthday) yrs 91	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME James Leonard			14. MOTHER'S MAIDEN NAME Tillie Yost		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address Records; Spring Grove State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerotic C.V.D. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 12 hrs and 5 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 31 , 19 59 , to September 5 , 19 59 , that I last saw the deceased alive on September 5 , 19 59 , and that death occurred at 1:20 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Gertrude J. Fleischmann M.D. Spring Grove State Hospital 9. 5 1959					
ACTUAL SIGNATURE Gertrude J. Fleischmann M.D. Spring Grove State Hospital 9. 5 1959					
PHYSICIAN'S NAME (Type) GERTRUDE J. FLEISCHMANN Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-7-59		22c. NAME OF CEMETERY OR REPOSITORY Dulany Valley Memorial	
22d. LOCATION (City, town, or county) (State) Baltimore Maryland		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm Cook - Blight, Inc 6009 Harford Rd.			
24a. REC'D BY REGISTRAR DATE SEP 9 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

MEDICAL CERTIFICATION

TO BE COMPLETED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR
may be retained.

TO FUNERAL DIRECTOR:
page 3 should be retained by
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the hospital or attending physician.

OR: After this certificate has been signed by the attending physician and completely filled in by the registrar, it should be attached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them with the registrar.

Death: Page 4

Funeral director,
should be filed with,

15M 9/35

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09987

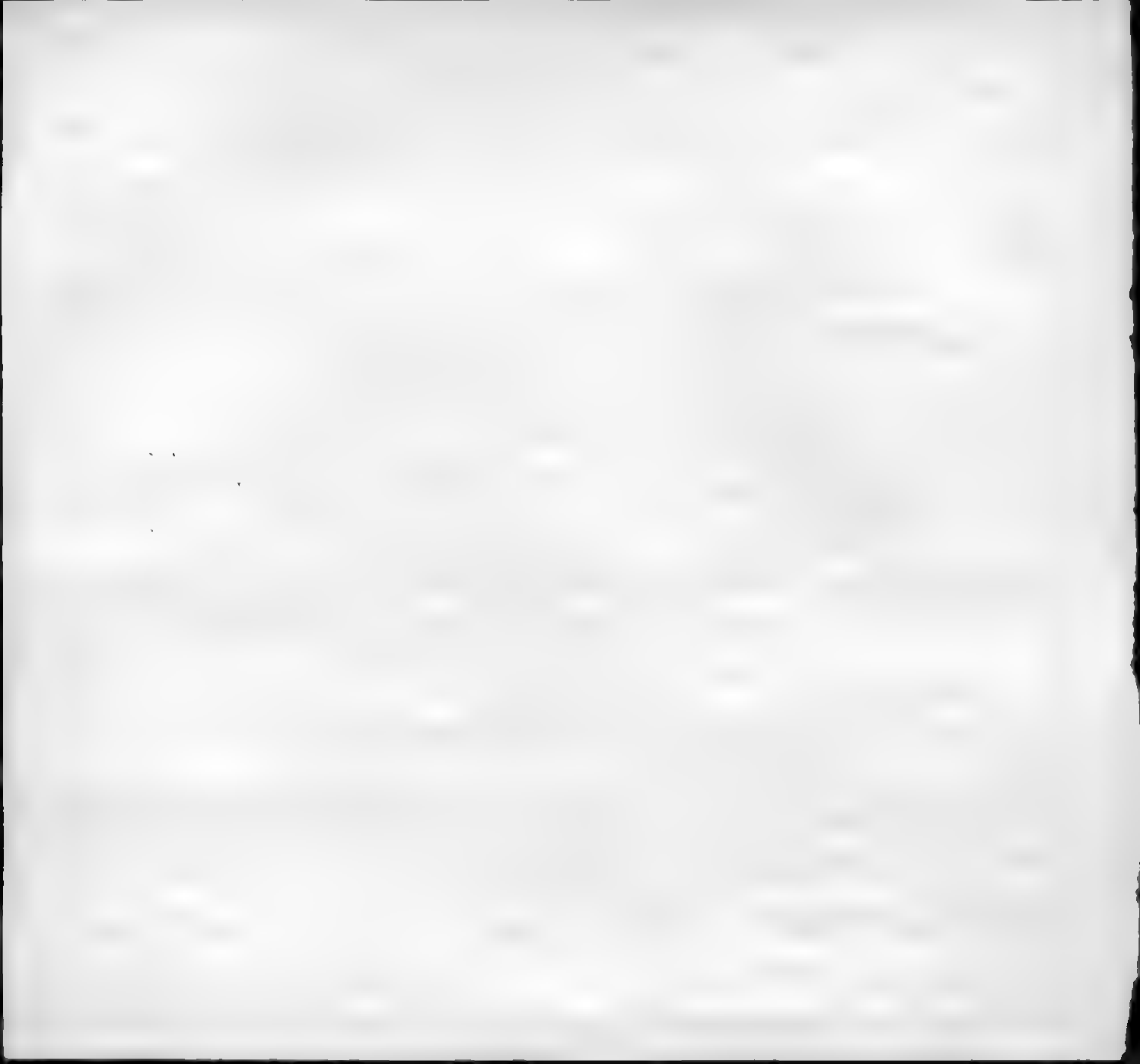
CERTIFICATE OF DEATH

09960

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ARMACOST NURSING HOME</u>		d. STREET ADDRESS— <u>43 Franklin St.</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>W.</u> Last <u>MARVELL</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 15, 1871</u>
9. AGE (In years last birthday) <u>88</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Wynkoop</u>		14. MOTHER'S MAIDEN NAME <u>Emily Nippes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Oliver Marvell Tower Farm New Britain Pa.</u>		Address <u>R.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Conclusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiac</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>10 yrs</u> <u>if</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 20, 1959</u> to <u>Sept 20, 1959</u> , that I last saw the deceased alive on <u>Sept 20, 1959</u> , and that death occurred at <u>11:11 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. C. D. M.D.</u>		ADDRESS (Street, city or town, state) <u>1111 York St Annapolis Md</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. C. D. M.D.</u>		DATE SIGNED <u>Sept 24, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u> </u>	<u>SEPT 24, 1959</u>	<u>US NAVAL ACADEMY</u>	<u>ANNAPOLIS MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR & SONS</u>		ADDRESS <u>ANNAPOLIS MD</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION



C9988

CERTIFICATE OF DEATH

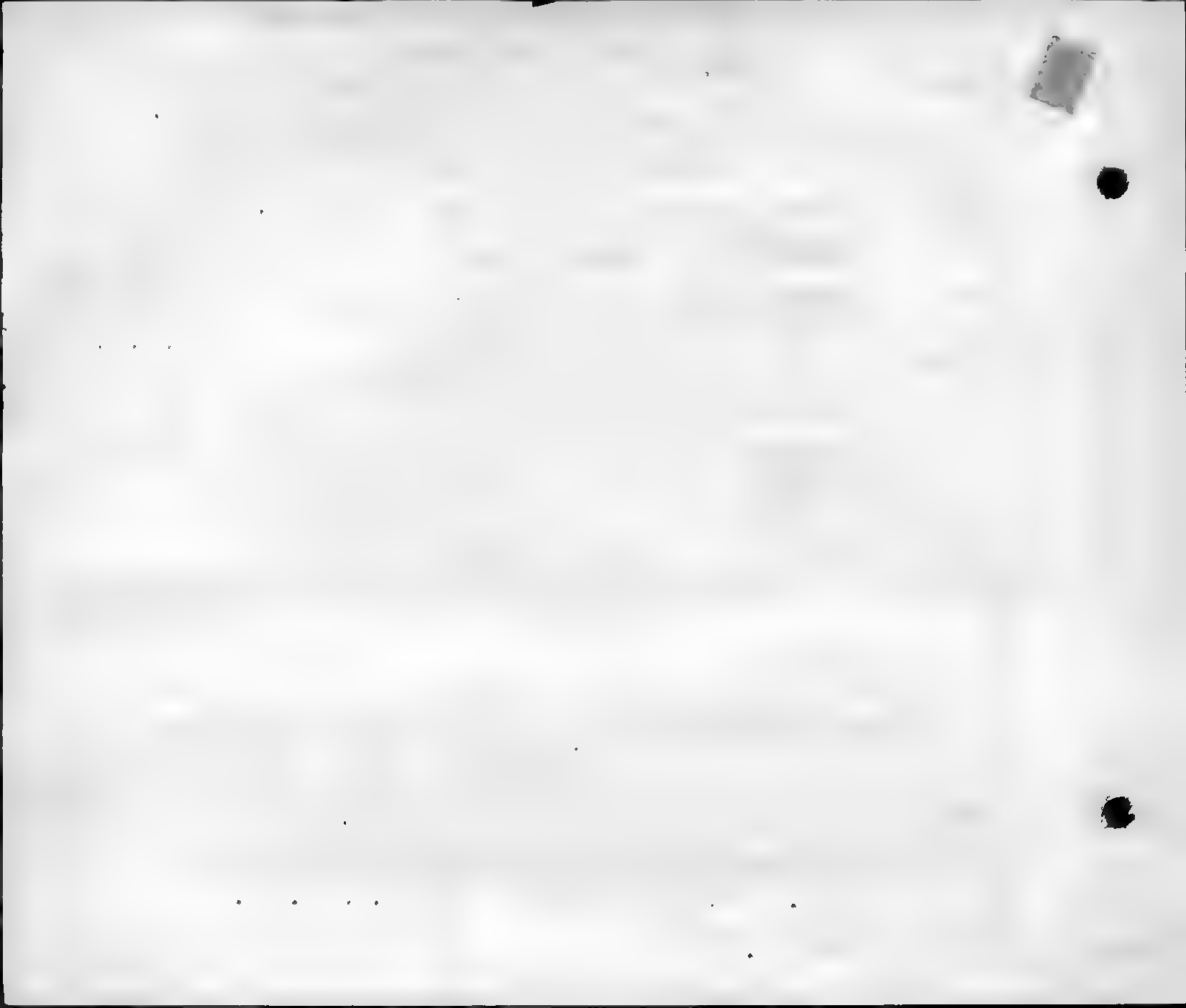
Reg. Dist. No.

09961

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 205 Garden Ridge Rd.	
3. NAME OF DECEASED (Type or print) Bernardine Catherine Masters		4. DATE OF DEATH Month Sept. Day 14 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1874
9. AGE (In years last birthday) yrs. 84		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Mryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Theodore Braun		14. MOTHER'S MAIDEN NAME Elizabeth Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Valvular disease DUE TO (c) Valvular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 11, 1959 to Sept. 14, 1959 , that I last saw the deceased alive on Sept. 13, 1959 , and that death occurred at 11:2 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Anthony S. ... M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9-14-59	
PHYSICIAN'S NAME (Type) ANTHONY S. ...		Catonville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 16/59	22c. NAME OF CEMETERY OR CREMATORY Holy Cross	22d. LOCATION (City, town, or county) (State) A.A. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE SEP 16 '59	24b. REGISTRAR'S SIGNATURE Catharine H. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09962

09989

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frank		4. DATE OF DEATH September 6 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1896
9. AGE (In years last birthday) 63 yrs		10. IF UNDER 1 YEAR: Months 6 Days 19 Hrs 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) optometrist		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 1917-17 mo.		16. SOCIAL SECURITY NO	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension 653X DUE TO Condit ons, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute Pyelonephritis DUE TO (c) Urinary stricture		INTERVAL BETWEEN ONSET AND DEATH 17 days 17 days + 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 2, 1954 to Sept. 6, 1959 , that I last saw the deceased alive on Sept. 6, 1959 , and that death occurred at 2:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Isidore Tuck, M.D.		DATE SIGNED Spring Grove State Hosp. Catonsville	
PHYSICIAN'S NAME (Type) Isidore Tuck, M.D.		M.D. Isidore Tuck, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/7/59	
22c. NAME OF CEMETERY OR CREMATORY Isidore Tuck		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Isidore Tuck, M.D.		24a. REC'D BY REGISTRAR DATE 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

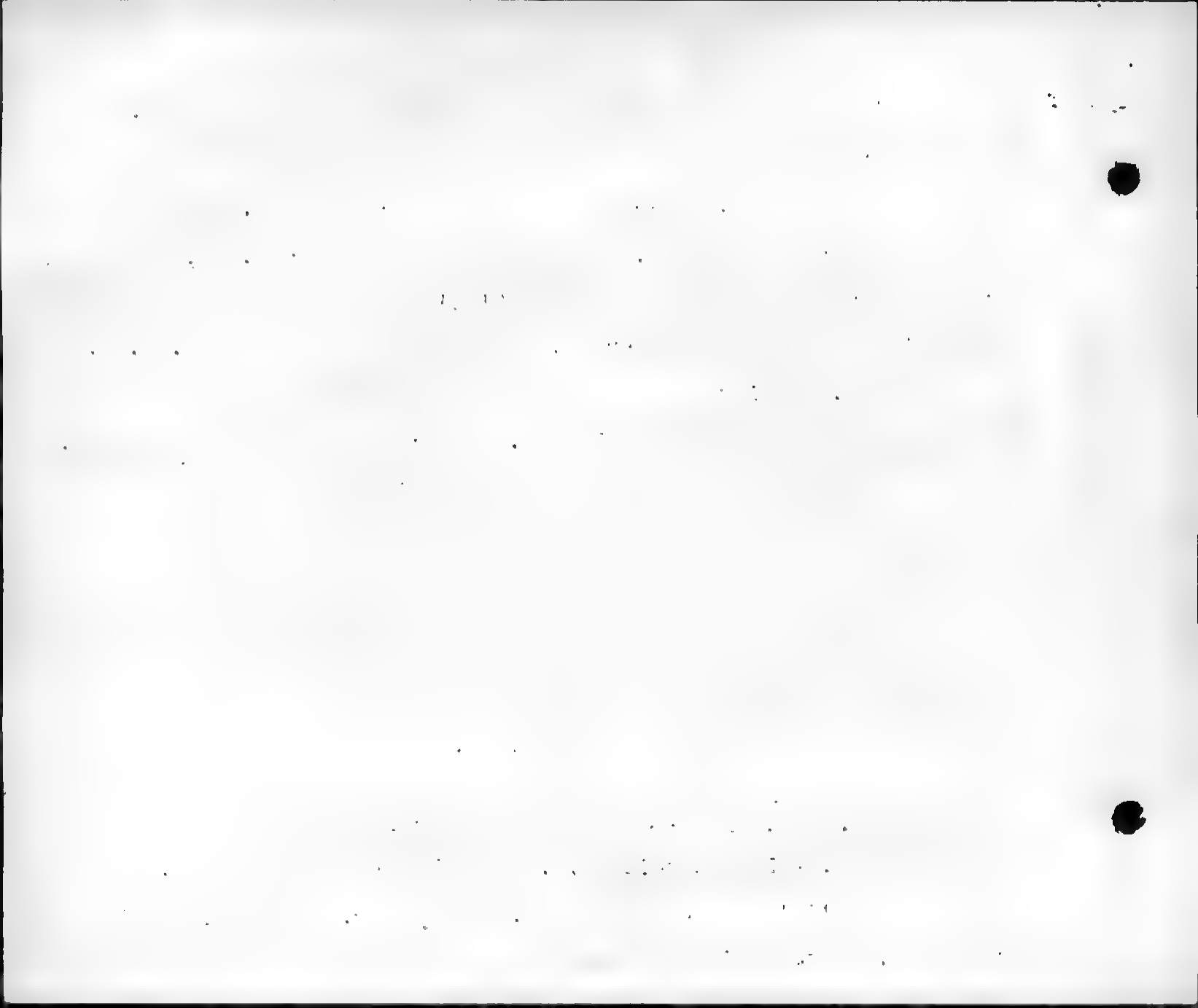


09990

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2622 Gwynndale Avenue		d. STREET ADDRESS 2622 Gwynndale Ave.	
3. NAME OF DECEASED (Type or print) Anna C. Messick		4. DATE OF DEATH Sept. 10, 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10'26'1899
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Krammer Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gus C. Messick		14. MOTHER'S MAIDEN NAME Hattie Larmore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 214-03-2913	
17. INFORMANT Mrs. Emma Willing		Address 4001 Cranston Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO HYPERTENSION Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 1958 to SEPT 1959 , that I last saw the deceased alive on Sept 4, 1959 , and that death occurred at 2 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Lee J. Volenick M.D.		ADDRESS (Post, city or town, state) 4710 Liberty Heights Ave DATE SIGNED	
PHYSICIAN'S NAME (Type) Lee J. Volenick		M.D. 4710 Liberty Heights Ave.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9'13'59	
22c. NAME OF CEMETERY OR CREMATORY Bivalve Meth. Church Cem.		22d. LOCATION (City, town, or county) (State) Bivalve, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
24a. REC'D BY REGISTRAR SEP 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. King	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09895 09864

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1827 EAST AVENUE				d. STREET ADDRESS 1827 EAST AVENUE			
3. NAME OF DECEASED (Type or print) First JOHN Middle Last MICKLISH				4. DATE OF DEATH Month SEPT. Day 12 , Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1914	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) beef boner		10b. KIND OF BUSINESS OR INDUSTRY Geotze's Meat		11. BIRTHPLACE (State or foreign country) Ellwood City, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Constantine Micklish				14. MOTHER'S MAIDEN NAME Ursula Kibert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War II 200-01-1382		17. INFORMANT Mrs. Julianna Micklish		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/13/59			
EXAMINER'S NAME (Type) M.B. Davis M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 15, 1959	22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTIMORE MD.				24a. REC'D BY REGISTRAR DATE SEP 15 '59		24b. REGISTRAR'S SIGNATURE Charles S. Knecht	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to removal, or removal.



1
FOR STATE
HEALTH DEPT.

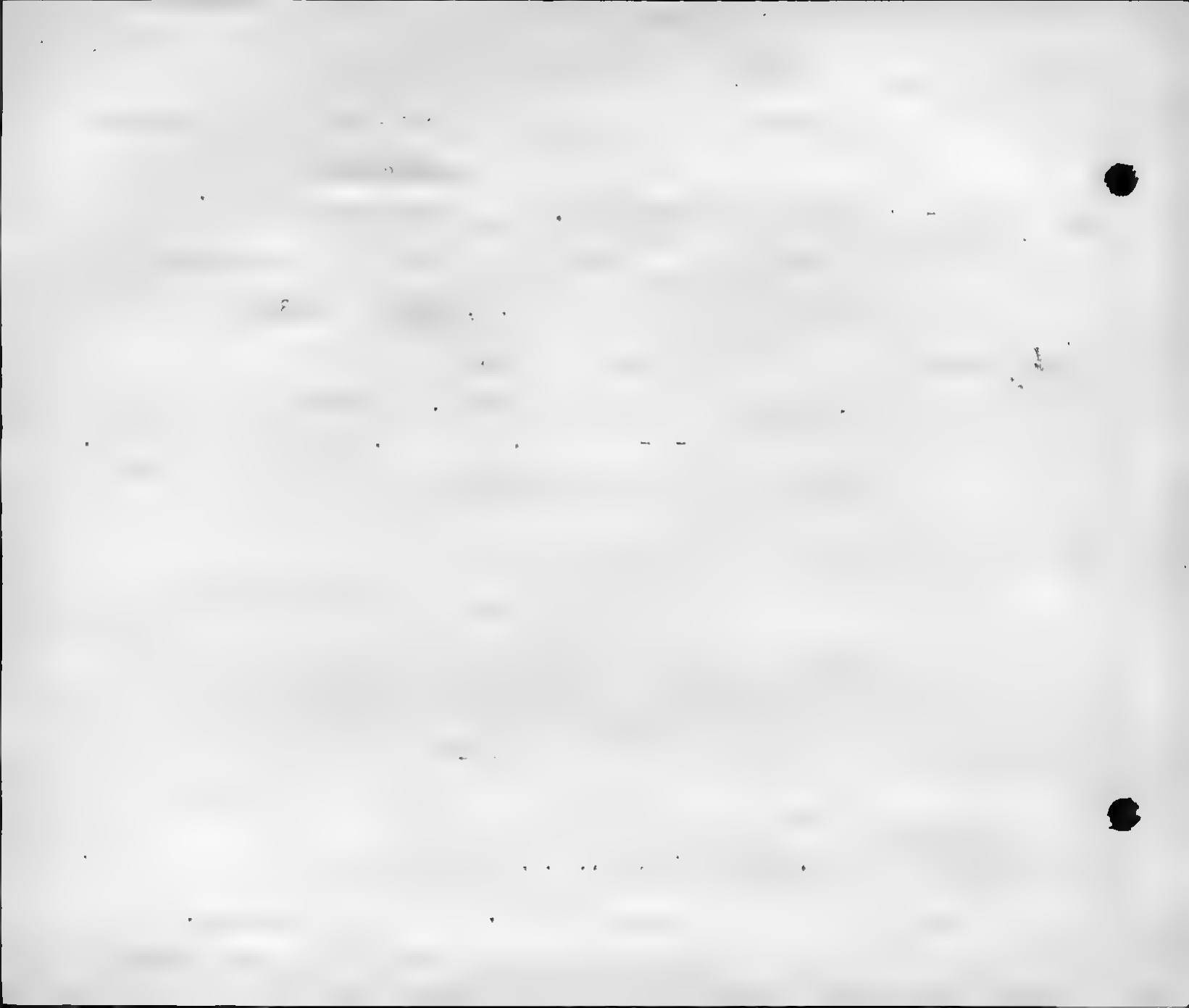
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE		Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Ellicott City		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Farm - Franklinville, off Reynolds Rd.		d. STREET ADDRESS		74 College Ave.		6502 Harmon Avenue			
3. NAME OF DECEASED (Type or print)		WILLIAM HARRY MILLER		4. DATE OF DEATH		September 25		1959			
5. SEX		Male		6. COLOR OR RACE		White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years, if UNDER 25, if UNDER 24 HRS., last birthday)		43 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Owner		10b. KIND OF BUSINESS OR INDUSTRY		Restaurant	
11. BIRTHPLACE (State or foreign country)		D. C.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		Frederick W. Miller		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		no		16. SOCIAL SECURITY NO		218-05-2976		17. INFORMANT		Maud V. Von Schmeide	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Carbon Monoxide Intoxication		Interval Between Onset and Death		Address		Ellicott City, Md	
973.1		DUE TO		(b)				Mrs. Virginia A. Miller - 74 College Ave.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE		W. Bradley King, Jr., M.D.		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		W. Bradley King, Jr., M.D.		DATE SIGNED		9/26/59					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country)		(State)			
Burial		9/28/59		Druid Ridge Cen.		Pikesville, Md.					
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		DATE SEP 30 '59					
J. J. Schickel				Charles A. King							

9365



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

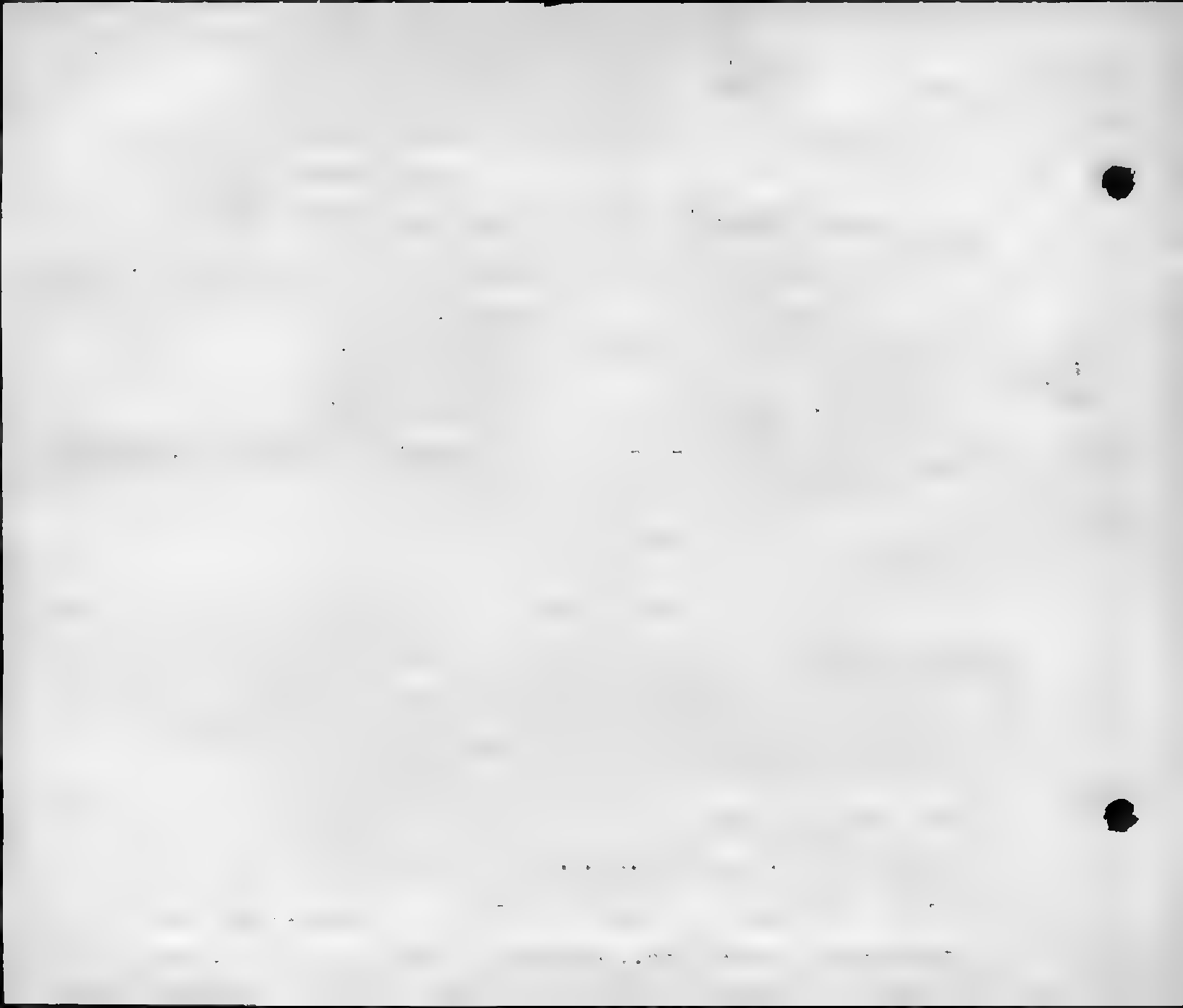
Items 18-20 Fillm 249 9-MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05966

09992

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY <u>Baltimore</u>				a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jones Creek (19)</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>7334 Waldman, Sparrows Point</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County Jail</u>				e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
<u>WILLIAM JOHN MILLER</u>				<u>September 19, 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<u>May 27, 1929</u>		9. AGE (in years) (If UNDER 1 YEAR IF UNDER 24 HRS last birthday) <u>30</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter J. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Anna Rebar</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes WWII</u>				16. SOCIAL SECURITY NO. <u>175-20-6868</u>			
17. INFORMANT <u>John Miller</u>				Address <u>64 Willow Spring Road Baltimore 22, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intoxication</u>							
<u>874.7</u> DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>paraldehyde poisoning</u>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ingested paraldehyde</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>9/19/59</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Balto. Co. Jail</u>		20f. (City or town) (County) (State) <u>Towson Baltimore Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>W. V. Lovitt, Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9/19/59</u>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/22/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial</u>		22d. LOCATION (City, town, or country) (State) <u>Bel Air, Maryland</u>	
23. FUNERAL DIRECTOR <u>Walter Brooks Bradley, Inc., Dundalk 22</u>				ADDRESS			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kiang</u>			



00993 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2603 Royal Oak Avenue				STREET ADDRESS (If rural give location) 2603 Royal Oak Avenue			
3. NAME OF DECEASED: (First) EDWARD (Middle) ESAU (Last) MINOR				4. DATE OF DEATH: (Month) September (Day) 27 (Year) 1959			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed		8. DATE OF BIRTH: May 15, 1884	
				9. AGE last birthday: 75 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Special Representative		10b. KIND OF BUSINESS OR INDUSTRY: American Express		11. BIRTHPLACE (State or foreign country): Marriottsville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: George C. Minor				14. MOTHER'S MAIDEN NAME: Lucy Shakelford Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Alice M. Kachadourian-2603 Royal Oak Ave.			

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) Cerebral Hemorrhage		DUE TO		1 week	
Antecedent cause(s) (b) Arteriosclerosis		DUE TO		5 years	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
12a. DATE OF OPERATION:		12b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 7, 1946 , to Sept. 27, 1959 , that I last saw the deceased alive on Sept. 27, 1959 and that death occurred at 1:10 P.M. , from the causes and on the date stated above.					
SIGNATURE W. B. Leavins		ADDRESS 218 E. University Pkwy. Balto 18, Md.		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 10/1/1959		NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
DATE RECD BY LOCAL REGISTRAR'S SIGNATURE SEP 30 '59		24. FUNERAL DIRECTOR Ellsworth Armacost		LOCATION (City, town, or county) (State) Woodlawn Maryland	
				ADDRESS 4600 Liberty Hghts. Av	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
0999 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 537 Edgar Avenue					d. STREET ADDRESS 537 Edgar Avenue						
3. NAME OF DECEASED (Type or print) George William Moore					4. DATE OF DEATH Month 9 Day 27 Year 1959						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-23-1906		9. AGE (In years last birthday) 53 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter					10b. KIND OF BUSINESS OR INDUSTRY Bus Business					11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Samuel A Moore					14. MOTHER'S MAIDEN NAME Alvina Haas					12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. 212-07-1601					17. INFORMANT Mildred Moore Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery sclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c) 											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour 9 a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Russell S. Fisher					CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>						
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 9-30-59						
22c. NAME OF CEMETERY OR CREMATORY St. Matthew Cemetery					22d. LOCATION (City, town, or country) (State) Baltimore Md						
23. FUNERAL DIRECTOR Henry Grunski ADDRESS 1407 Eastern Ave 21					24a. REC'D BY REGISTRAR SEP 30 '59						
					24b. REGISTRAR'S SIGNATURE Arthur L. Hanna						

03968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial, transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Item 18 Film 240 1-25-59 ams										
09899										
CERTIFICATE OF DEATH										
Reg. Dist. No. 09969										
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b 1906 Barry Road d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1906 Barry Road					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 1 c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) 3 Dundalk d. STREET ADDRESS 1906 Barry Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) FREYA First MUELLMER Middle 19 Last					4. DATE OF DEATH Sept 3/59 Month 19 Day 19 Year					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar 13 1905 54		9. AGE (In years lost birthday) 54 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Switzerland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Don't know					14. MOTHER'S MAIDEN NAME Don't know					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO --		INFORMANT Theron Whited 1906 Barry Road			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) anemia DUE TO (b) multiple myeloma Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) 1 mos.										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
MEDICAL CERTIFICATION										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Sept 2, 1959 to 9-3-59 , that I last saw the deceased alive on 9-3-59 , and that death occurred at 9:14 P.M. from the causes and on the date stated above.										
ACTUAL SIGNATURE Lester Lebo M.D.					ADDRESS (Street, city or town, state) 1801 Eutaw Place, Baltimore 17, Maryland					
DATE SIGNED										
PHYSICIAN'S NAME (Type) LESTER LEBOWITZ, M.D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Sept 5/59		22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge			22d. LOCATION (City, town, or county) (State) Howard Co			
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road					ADDRESS		24a. REC'D BY REGISTRAR SEP 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



09995

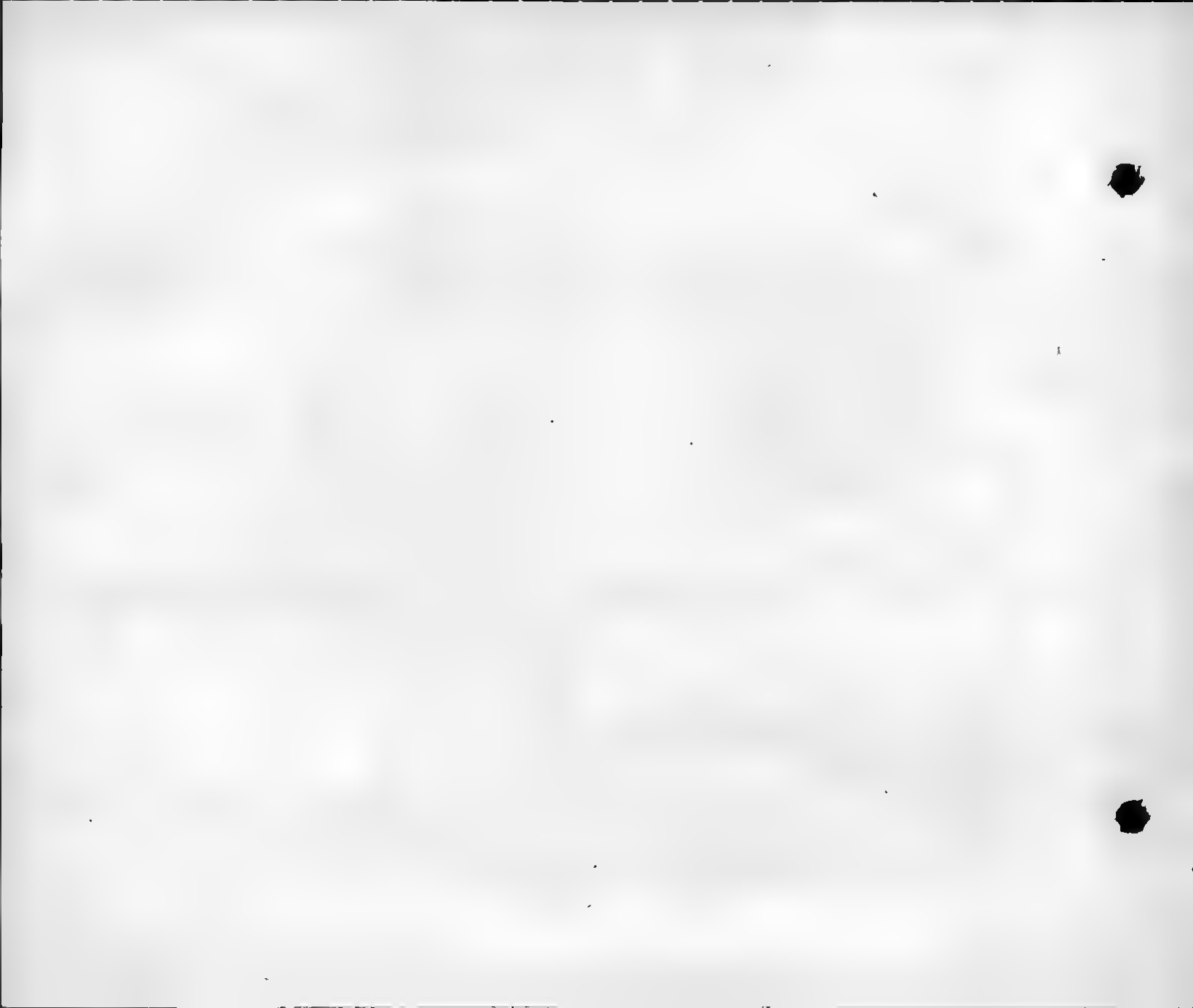
CERTIFICATE OF DEATH

09970

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>436 Old Trail</u>				d. STREET ADDRESS <u>436 Old Trail</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret M. Murphy</u>				4. DATE OF DEATH Month Day Year <u>Sept 26 1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 7 1883</u>	
9. AGE (In years lost birthday) <u>75</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House Work</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Alexander Mc Carthy</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Mc Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>BEATRICE M. MURPHY</u> Address <u>436 Old Trail</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Branchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia pneumonia</u> DUE TO <u>1 week</u> (c) <u>arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 15, 1957</u> to <u>Sept 26, 1959</u> that I last saw the deceased alive on <u>Sept 25, 1959</u> and that death occurred at <u>5:45 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George T. Gilmore</u> M.D.				ADDRESS (Street, city or town, State) <u>Luthersville, Md</u> DATE SIGNED <u>9/28/59</u>			
PHYSICIAN'S NAME (Type) <u>GEORGE T. GILMORE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 30-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town or county) (State) <u>Fredrick Rd Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles B. ...</u> ADDRESS <u>7110 Belair Rd</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur G. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

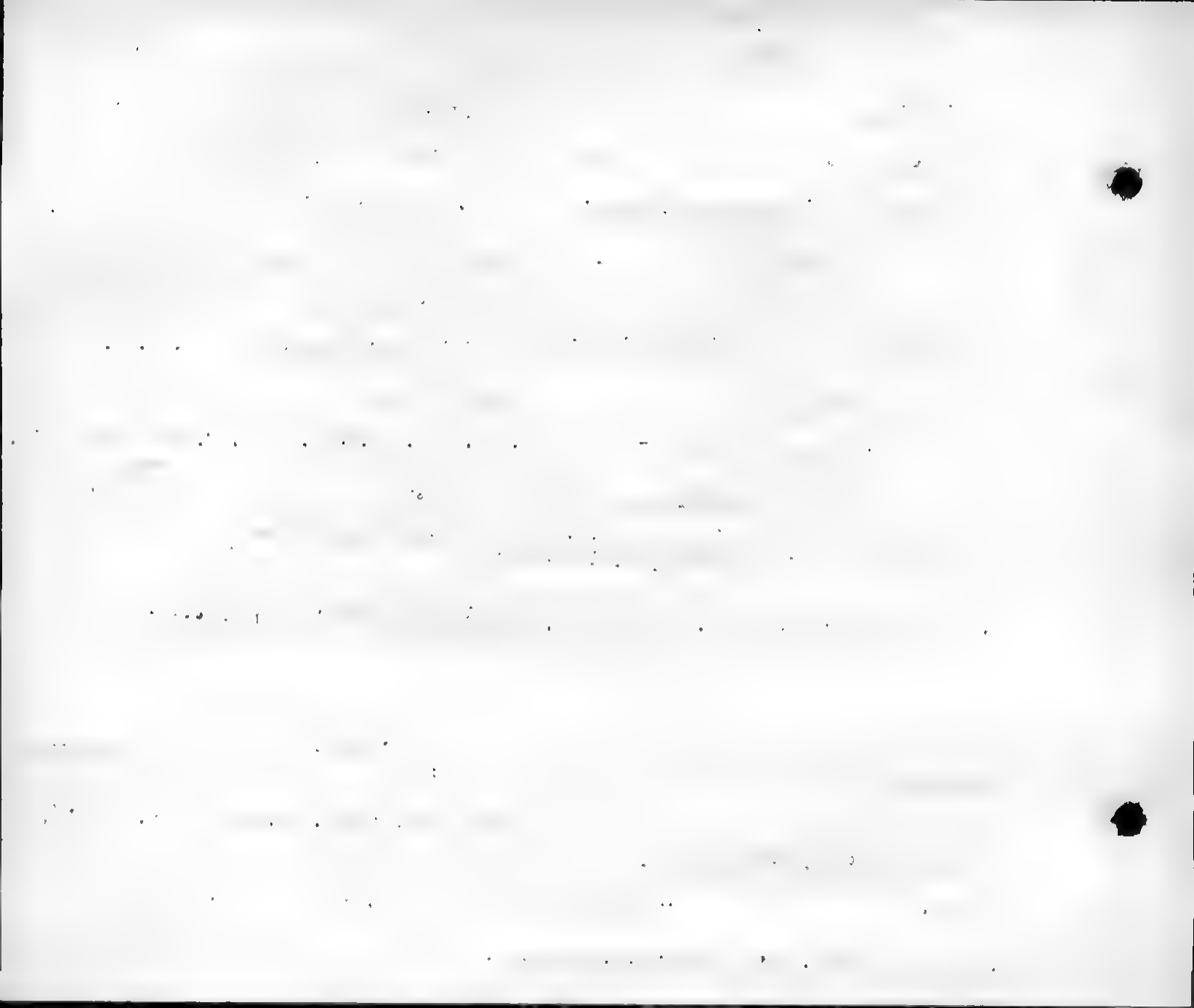
09996

CERTIFICATE OF DEATH

Reg. Dist. No.

09971

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN Tb 77 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 7922 Gregory Drive			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MELVIN Middle L. Last MYERS				4. DATE OF DEATH Month September Day 19 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 3, 1921	
9. AGE (In years last birthday) 37 yrs		10. IF UNDER 1 YEAR Months 37 Days 37 Hours 37 Min 37		11. BIRTHPLACE (State or foreign country) Westminster, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY (Tractor Tractor)			
13. FATHER'S NAME Peter Myers				14. MOTHER'S MAIDEN NAME Mattie Riley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II				16. SOCIAL SECURITY NO. 212-16-4379			
17. INFORMANT Clin. Rec., Vet. Adm. Hosp. Balto. Md. Fort Howard Div.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY CONGESTION AND EDEMA DUE TO 191 METASTATIC SQUAMOUS CELL CARCINOMA, SKIN OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ABDOMEN, THIGHS AND BACK (b) ABDOMEN, THIGHS AND BACK (c) INTERVAL BETWEEN ONSET AND DEATH RECENT 21 MONTHS				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. . SURGICAL ABSENCE, PENIS. EMACIATION. Amputation of penis. Doctor's Hospital			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 4 19 59 to September 19 19 59 and that death occurred at 2:45 P M, from the causes and on the date stated above				ADDRESS (Street, city or town, state) DATE SIGNED M.D. VAH, BALTO 18, MD. FT. HOWARD DIV. 9/21/59			
ACTUAL SIGNATURE DAVID A. OUSTON, M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-22-59		22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cemetery Westminster, Maryland		22d. LOCATION (City, town, or county) (State) Westminster, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Chok, Blight, Inc. 6009 Harford Rd., Balto, Md.				24a. REC'D BY REGISTRAR SEP 24 '59			
24b. REGISTRAR'S SIGNATURE C. L. H. & K. H.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

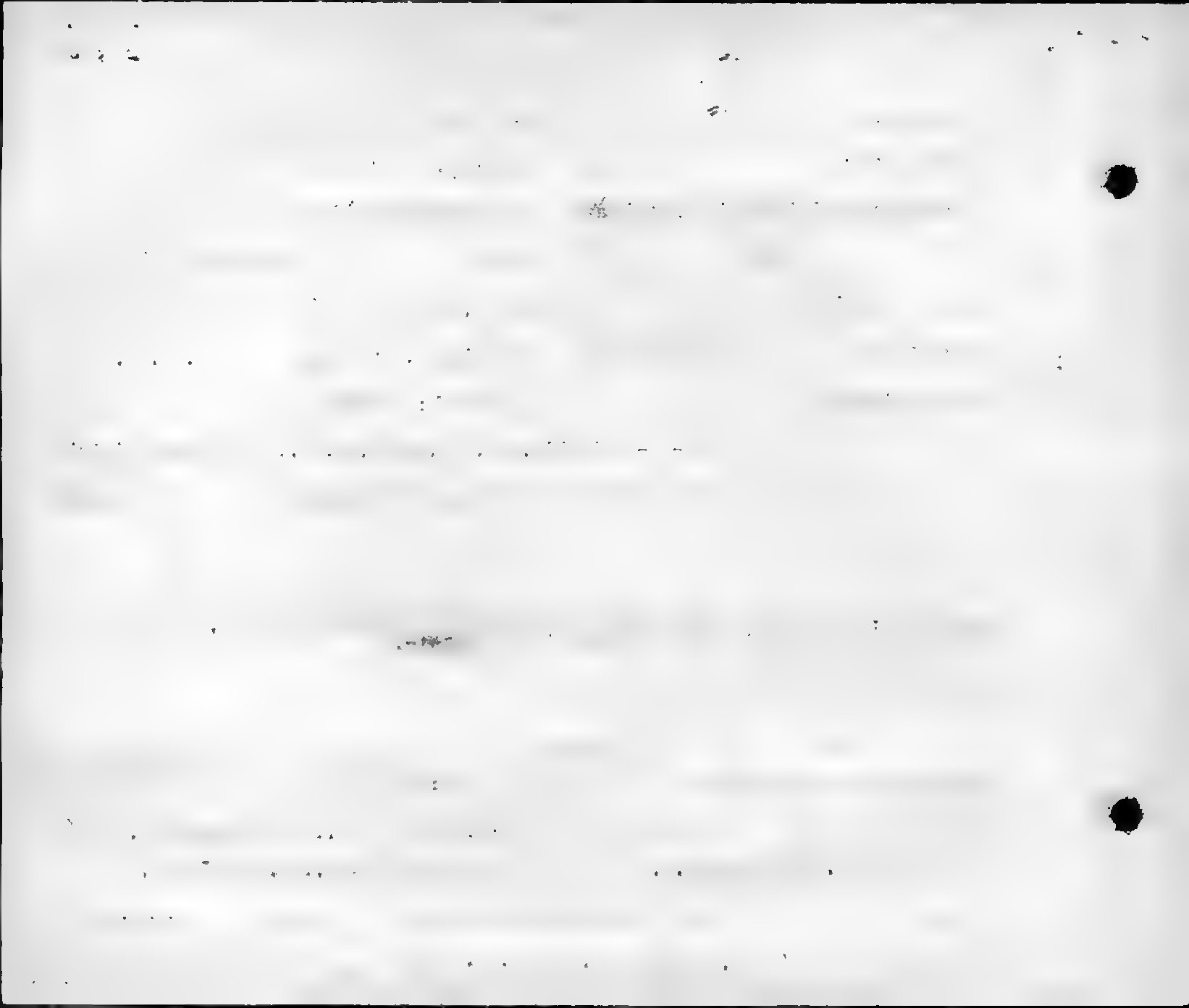
09997

CERTIFICATE OF DEATH

Reg. Dist. No.

10922

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 19 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission on) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (30) d. STREET ADDRESS 1604 Clarkson Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD R NEISSER		4. DATE OF DEATH Month Day Year September 1 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1890
9. AGE (In years last birthday) 69		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Blower		10b. KIND OF BUSINESS OR INDUSTRY Glass Factory	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Neisser		14. MOTHER'S MAIDEN NAME Euna M. Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 212-05-9723	
17. INFORMANT Clin. Rec. V.A.H., Balto., Md., Fort Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] + PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). ADENOCARCINOMA OF RECTUM WITH METASTASES 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation: Exploratory Laparotomy and Transverse Colostomy 3/17/59. Inoperable adenocarcinoma of rectum filling pelvis.		INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 13, 1959 to September 1, 1959 and that death occurred at 8:03 A. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTO 18, MD., FORT HOWARD DIV. 9/1/59			
ACTUAL SIGNATURE John W. Crawford		M.D. VAH, BALTO 18, MD., FORT HOWARD DIV. 9/1/59	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH, BALTO 18, MD., FT. HOWARD DIV.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 4/1959	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard Evans		24a. REC'D BY REGISTRAR SEP 3 '59	
ADDRESS 1400 S. Charles St., Balto., Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09998

CERTIFICATE OF DEATH

09973

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 11yr2mth23dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 230 West 19th Street	
3. NAME OF DECEASED (Type or print) Loretta		4. DATE OF DEATH Month September Day 15 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1883
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Nolan		14. MOTHER'S MAIDEN NAME Bridget Coyne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrene of right foot		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 28, 1959 to Sept. 15, 1959 , that I last saw the deceased alive on Sept. 15, 1959 , and that death occurred at 4:25am , from the causes and on the date stated above.			
ACTUAL SIGNATURE Bruno Rabauskas M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9-15-59	
PHYSICIAN'S NAME (Type) BRUNO RABAUŠKAS		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Stewart M. Mendenhall		24a. REC'D BY REGISTRAR DATE SEP 16 59	
24b. REGISTRAR'S SIGNATURE Arthur E. Mendenhall			

100-1100

09999

CERTIFICATE OF DEATH

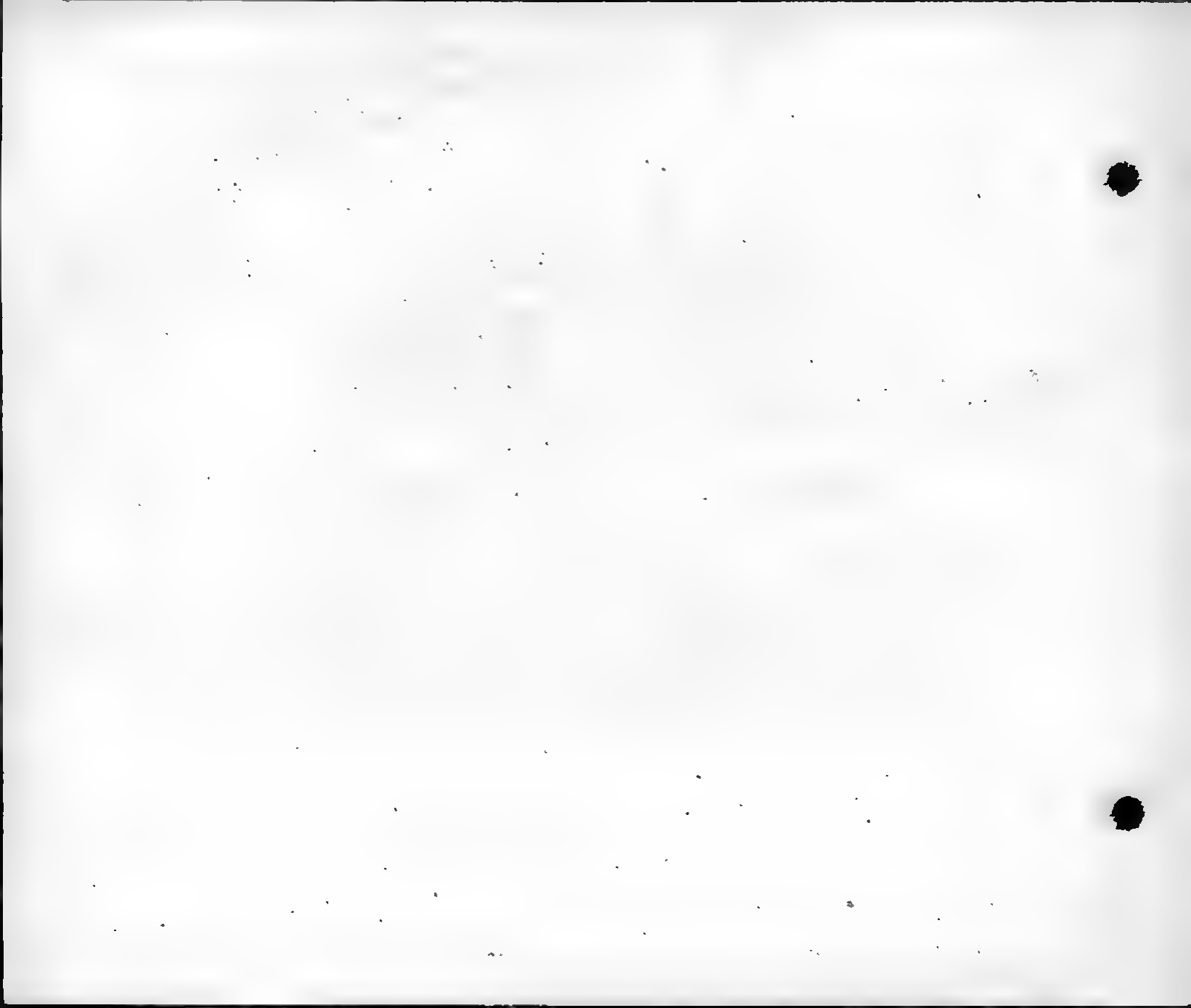
Reg. Dist. No.

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

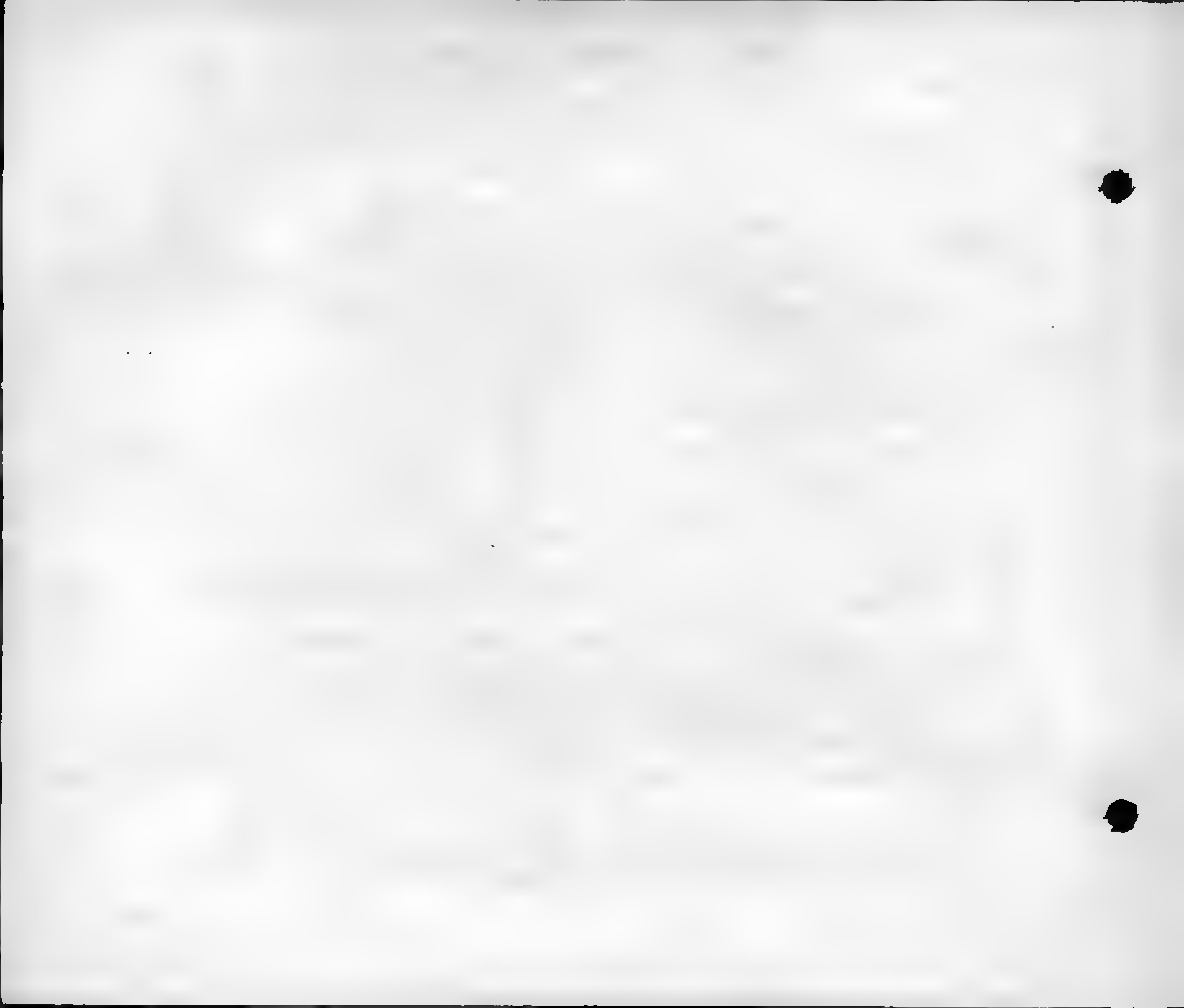
1 PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u> c. LENGTH OF STAY IN 1b <u>55 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Forlign Nursing Home</u>				2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York</u> d. STREET ADDRESS <u>1111 1st St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME <input checked="" type="checkbox"/> DECEASED (Type or print) <u>Mrs. Sara</u> First Middle Last <u>Oppenheimer</u> 4. DATE OF DEATH Month <u>Sept</u> Day <u>19</u> Year <u>1959</u>				5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH (Y) <u>Feb. 24, 1865</u> 9. AGE (In years last birthday) <u>94</u> IF UNDER 1 YEAR IF UNDER 24 HRS WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (State or foreign country) <u>MD</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Not known</u> 14. MOTHER'S MAIDEN NAME <u>Not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO <u>None</u> INFORMANT <u>Mrs H J. Windesheim</u> Address <u>808 Reisterstown Rd</u>				18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach with metastases</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>for years</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 26, 1959</u> to <u>19 Sep, 1959</u> that I last saw the deceased alive on <u>18 Sep, 1959</u> and that death occurred at <u>7:50 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>808 Reisterstown Rd</u> DATE SIGNED <u>19 Sep 59</u> ACTUAL SIGNATURE <u>Paul H Royse</u> M.D. <u>Pikesville 8 Md.</u> PHYSICIAN'S NAME (Type) <u>Paul H Royse</u>							
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23/FUNERAL DIRECTOR'S SIGNATURE <u>Paul H Royse</u> ADDRESS <u>2100 S. ...</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. ...</u>	



CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 535 Kingston Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Home Nursing Home		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Paulus		4. DATE OF DEATH September 23 19 59	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 5, 1874	
9. AGE (In years last birthday) yrs 85		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce dealer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Paulus		14. MOTHER'S MAIDEN NAME Dont know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. John Paulus 535 Kingston Road-20	
17. INFORMANT John Paulus 535 Kingston Road-20		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC CARDIO - VASCULAR DISEASE - 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRUINIA - SCLEROTIC DUE TO (c) FRAGILE CEF - HAD OLD		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/23 , 19 59 , to 9/23 , 19 59 , that I last saw the deceased alive on 9/23 , 19 59 , and that death occurred at 11 M, from the causes and on the date stated above ADDRESS (Street, city or town, state) 535 Kingston Road, Baltimore, Md. DATE SIGNED 9/23/59		ACTUAL SIGNATURE John H. Paulus M.D. 535 Kingston Road, Baltimore, Md.	
PHYSICIAN'S NAME (Type) John H. Paulus		DATE SIGNED 9/23/59	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/59	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Colgate, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE SEP 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

VS A15 (4)
15M 9/55



ARYLAND
05976

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File permit and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Carrington & Krause

VS. A15ME
5M 7/59



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

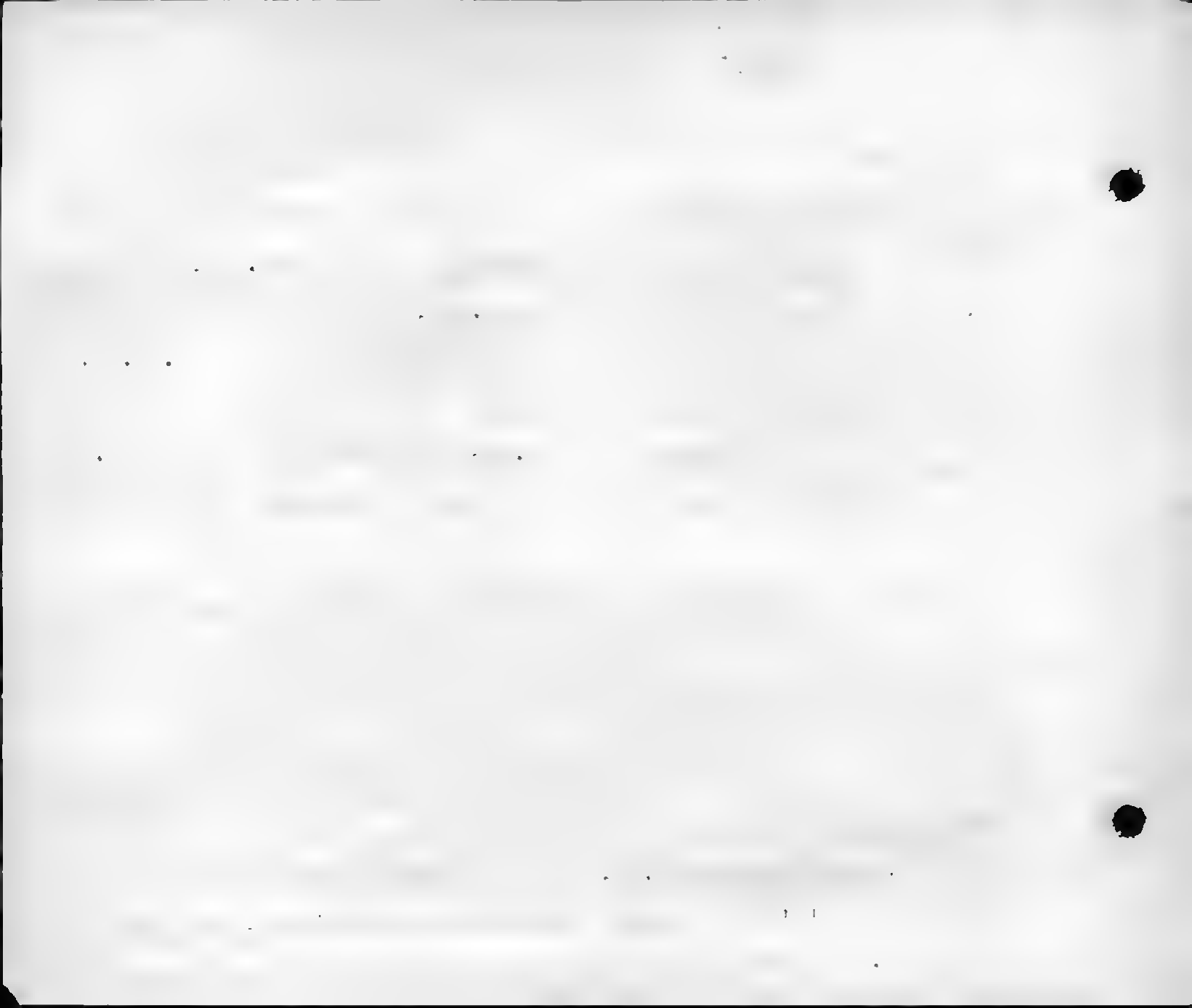
Reg. Dist. No.

09977

10002

1. PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a STATE Maryland b COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5738 First Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Amelia Middle Pfeiffer Last Pfeiffer		4. DATE OF DEATH Month Sept. Day 7 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1882
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Hettche		14. MOTHER'S MAIDEN NAME Christina Gonderman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Natalie Brown		Address 5738 First Ave. #27	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive failure - Chronic 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic obstructive pulmonary disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/1/59 to 9/7/59 , that I last saw the deceased alive on 9/7/59 , and that death occurred at 12:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE James Frederick M. D.			
PHYSICIAN'S NAME (Type) James Frederick M. D. 1305 KX Francis Avenue			
22a. BURIAL CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 9/9/59	
22c. NAME OF CEMETERY OR CREMATORY Laudon Park Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
24a. REC'D BY REGISTRAR SEP 10 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10003

CERTIFICATE OF DEATH

09978

Reg. Dist. No.

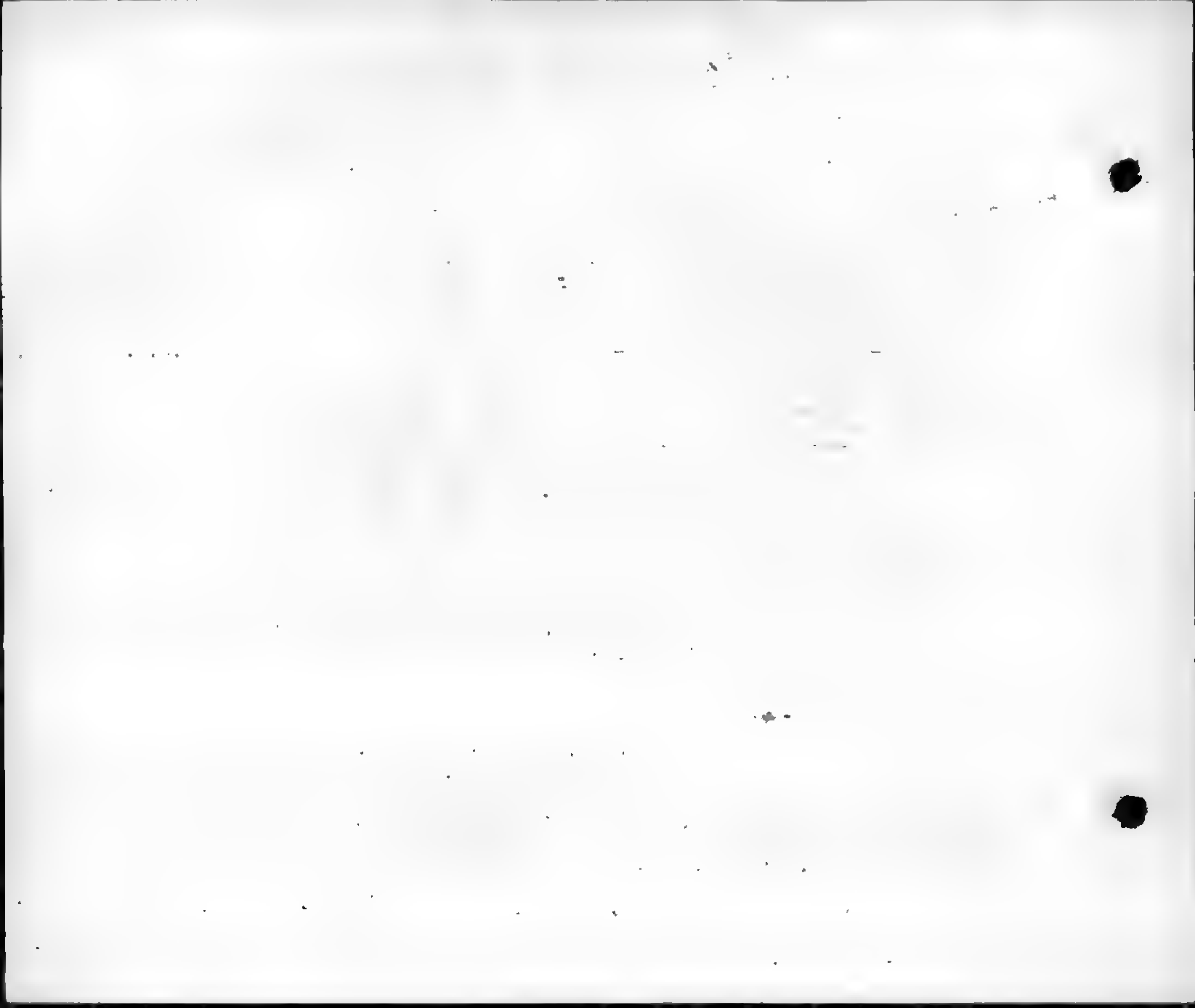
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace, Maryland d. STREET ADDRESS 550 Bourbon Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Larry Middle Dennis Last Poole		4. DATE OF DEATH Month 9 Day 29 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/13/59
9. AGE (In years last birthday) yrs 1 Months 1 Days 16		10. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) ---	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cecil Edwards		14. MOTHER'S MAIDEN NAME Pearl Cleo Zachry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. --- INFORMANT Rosewood Records Address ---	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive atelectasis of both lungs 762.0 DUE TO (b) --- Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (c) --- PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malformation of brain and spinal cord; microgyria; hydrocephalus; Arnold- 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Child's syndrome 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --- 20f. (City or town) --- (County) --- (State) ---			
21. I certify that I attended the deceased from Sept. 22, 1959 to Sept. 29, 1959 , that I last saw the deceased alive on 12 , and that death occurred at 6:00aM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rosewood State Training School Box 188 Owings Mills, Maryland DATE SIGNED Edward J. Mathews			
22a. BURIAL, CREMATION, REMOVAL (Specify) 10/1/59 22b. DATE THEREOF 10/1/59 22c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery 22d. LOCATION (City, town, or county) (State) Owings Mills Md			
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Elmer Sons Rustertown Md ADDRESS ---		24a. REC'D BY REGISTRAR 09/27/59 24b. REGISTRAR'S SIGNATURE William J. Thies	

1000232XV4

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10004
CERTIFICATE OF DEATH

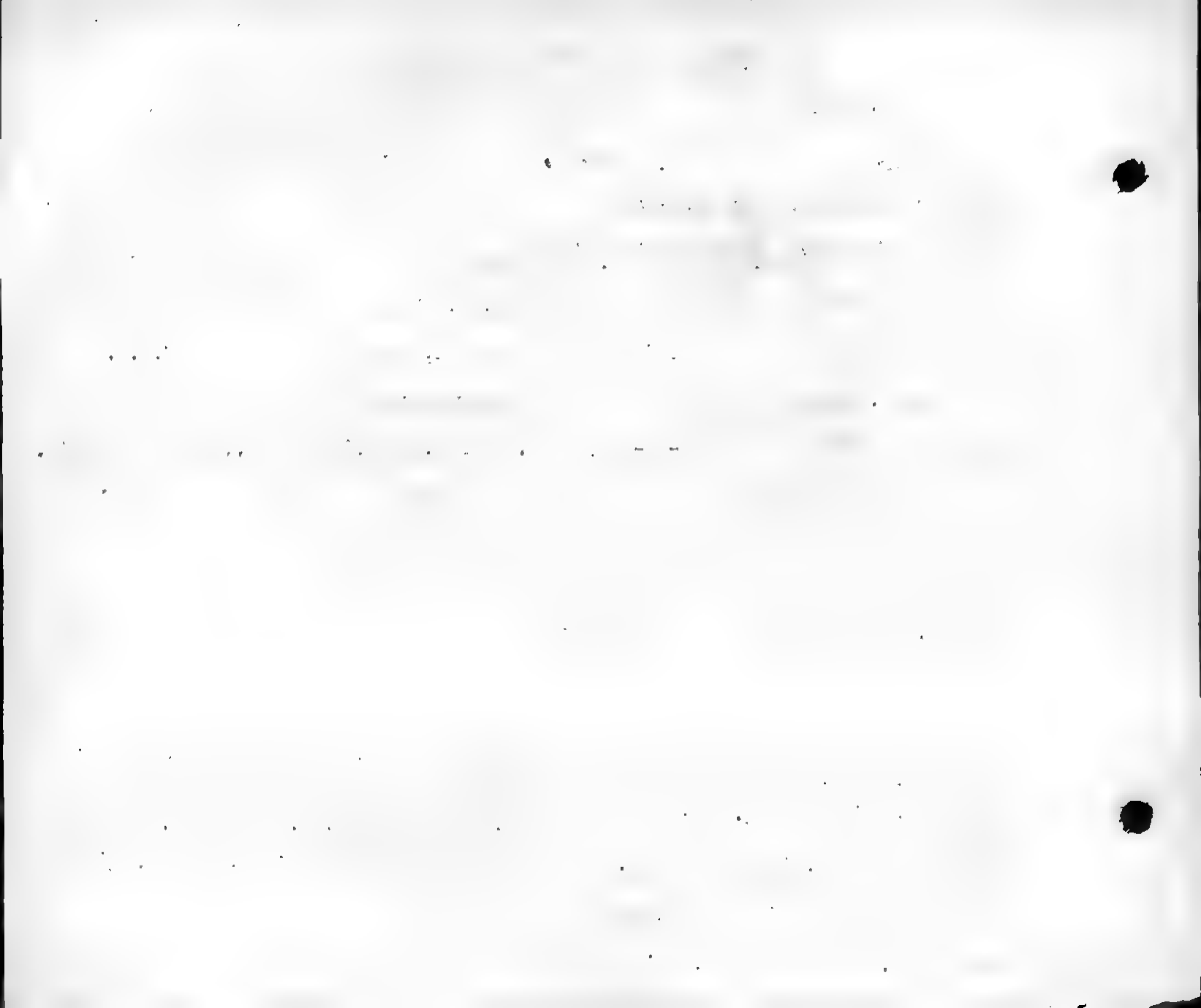
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Res dence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 117 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS Route 2	
3. NAME OF DECEASED (Type or print) Served As: CLARENCE (NMI) PURNELL First Middle Last CLARENCE W. PURNELL		4. DATE OF DEATH Month September Day 5 Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1894
9. AGE (in years last birthday) 65 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Berlin, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Purnell		14. MOTHER'S MAIDEN NAME Mary Butler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 217-09-1817	
17. INFORMANT Clin. Records, VAH Balto 18, Md., Fort Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RIGHT SIDE CEREBRAL THROMBOSIS 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 DAYS UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC RENAL DISEASE WITH NEPHROTIC SYNDROME			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20b. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 11 , 1959, to September 5 , 1959, and that death occurred at 11:58 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter C. Goldstein, M.D.		ADDRESS (Street, city or town, state) VAH, BALTO 18, MD. FT. HOWARD DIV. DATE SIGNED 9/6/59	
PHYSICIAN'S NAME (Type) WALTER C. GOLDSTEIN, M.D.		VAH, BALTO 18, MD. FT. HOWARD DIV. 9/6/59	
22a. BURIAL CREMATORY (Specify) Evergreen Cemetery		22b. DATE THEREOF 9/8/59	
22c. NAME OF CEMETERY OR CREMATORY Berlin, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		24a. REGISTERED BY REGISTRAR SEP 10 59	
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas		1808 N. Monroe Street Baltimore, Maryland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of death certificate and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58



10005

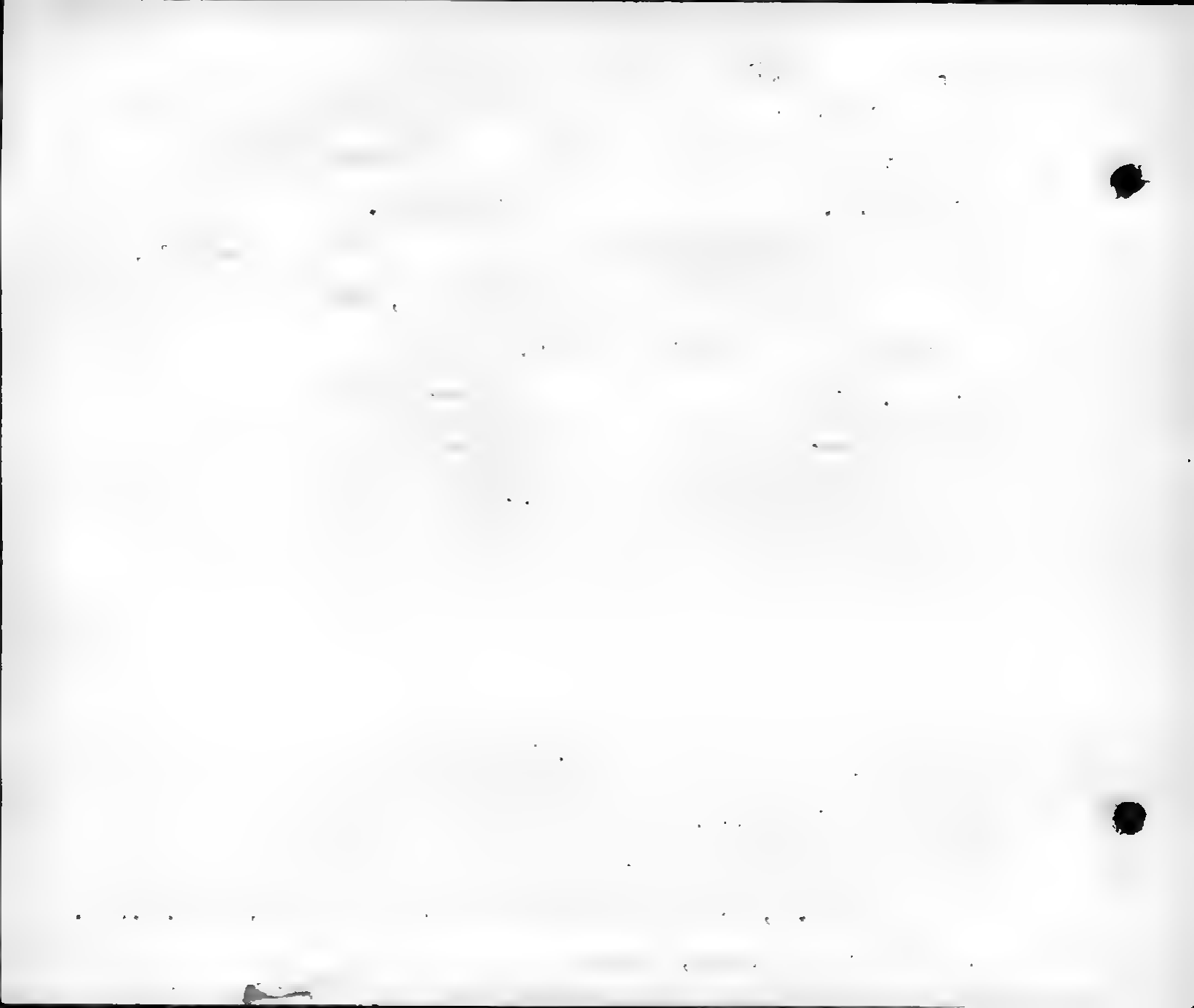
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville RD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville RD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gibbons Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last JAMES ROSS QUINN		4. DATE OF DEATH Month Day Year September 16, 1959	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 19, 1898
9 AGE (in years last birthday) yrs 60		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timekeeper	
10b. KIND OF BUSINESS OR INDUSTRY Bendix Radio Corp.		11 BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME James A. Quinn	
14 MOTHER'S MAIDEN NAME Emma Sauble		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None	
16 SOCIAL SECURITY NO. Family Records		17. WAS ALTPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS ALTPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 29th, 1959 to Sept. 16th, 1959 , that I last saw the deceased alive on Sept. 16th, 1959 , and that death occurred at 11 P. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 1927 YORK RD, TIMONIUH, Md 9/18/59 DATE SIGNED			
ACTUAL SIGNATURE M. X. Quinn M.D.		DATE SIGNED 9/18/59	
PHYSICIAN'S NAME (Type) MICHAEL KEVIN QUINN			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b DATE THEREOF Sept. 20, 1959	22c NAME OF CEMETERY OR CREMATORY Weisburg Methodist Cemetery	22d. LOCATION (City, town or county) (State) Weisburg, Balto. Co., Md.
23 FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a REC'D BY REGISTRAR DATE SEP 22 '59	
		24b. REGISTRAR'S SIGNATURE Arthur E. Knepp	

10 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

11 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

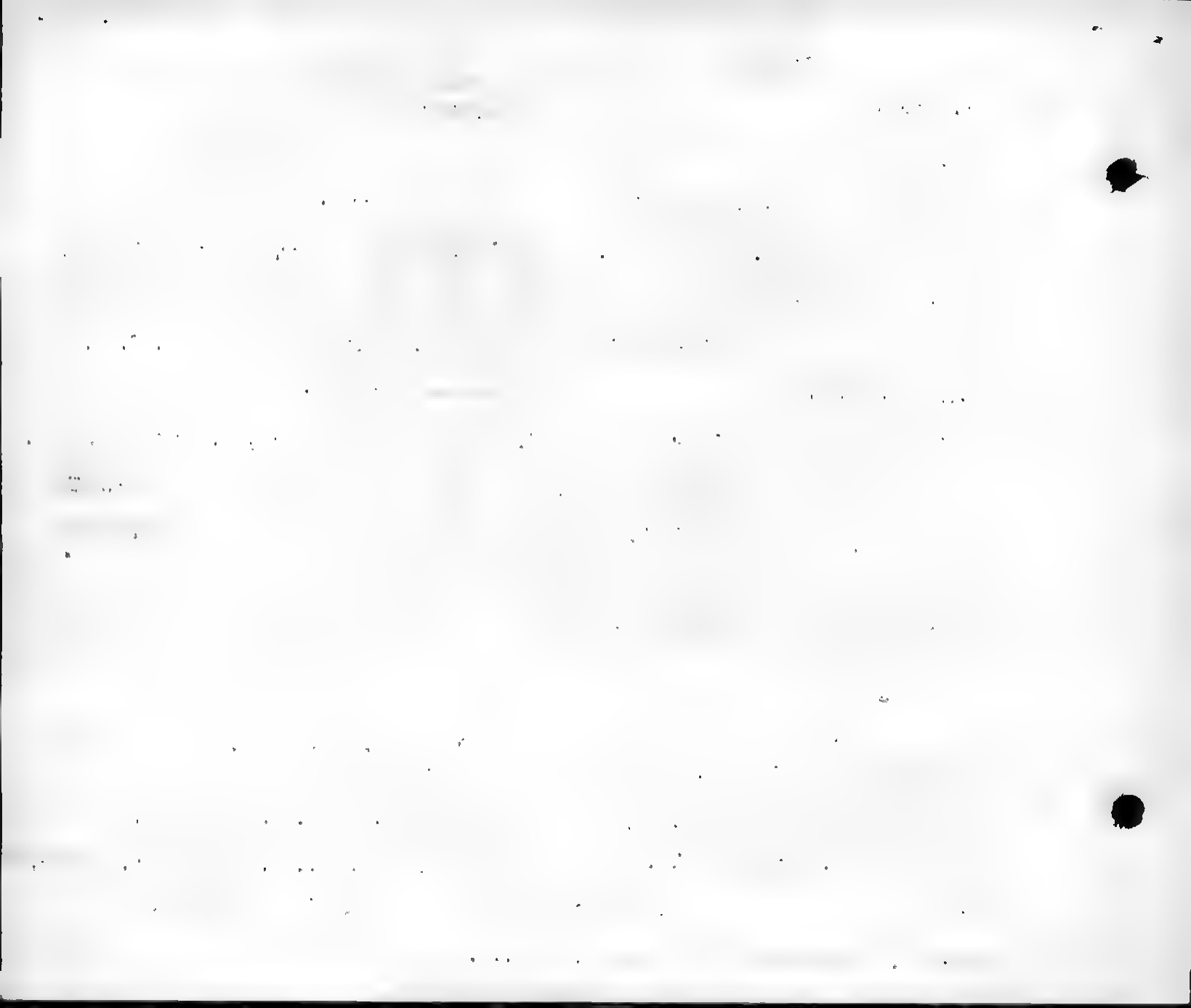
Reg. Dist. No.

10006

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. COUNTY Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 89 Days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (24)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 623 South Rose Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) JOSEPH		First M. Middle RACHUBINSKI		Last		4. DATE OF DEATH Month September Day 23 Year 1959	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH August 24, 1910	
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 49 Days 49 Hours 49 Min		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Tile Setting		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Michael Rachubinski				14. MOTHER'S MAIDEN NAME Susannah Gorczewicz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) W Yes		16. SOCIAL SECURITY NO WW II 216-07-2555		INFORMANT Address Clinical Records, Baltimore, Md. Fort Howard Div.			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE 581.1 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LAENNEC'S CIRRHOSIS DUE TO (c) UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Inactive Pulmonary Tuberculosis, Left 002 X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month June Day 26 Year 1959 Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 26 , 19 59 , to September 23 , 19 59 , and that death occurred at 1:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTIMORE MD, FT. HOWARD DIV. 9/23/59							
ACTUAL SIGNATURE John W. Crawford				PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-26-59			
22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery				22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Raymond I. Kaczorowski				24a. REC'D BY REGISTRAR SEP 30 '59			
ADDRESS 2525 Fleet St. Balto. Md.				24b. REGISTRAR'S SIGNATURE Quinn & Thoms			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the General Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

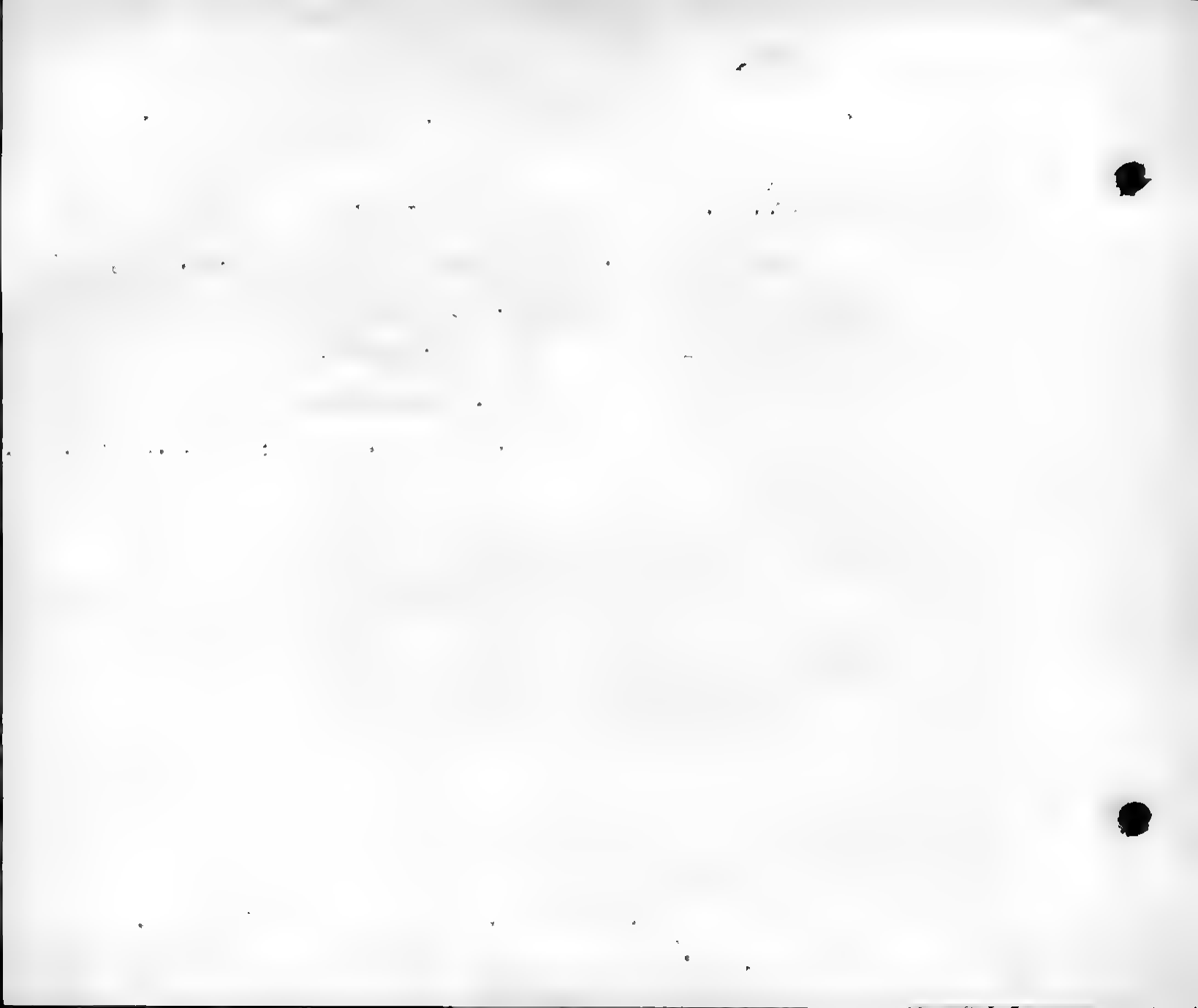


CERTIFICATE OF DEATH

§ 263.5 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

FOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B



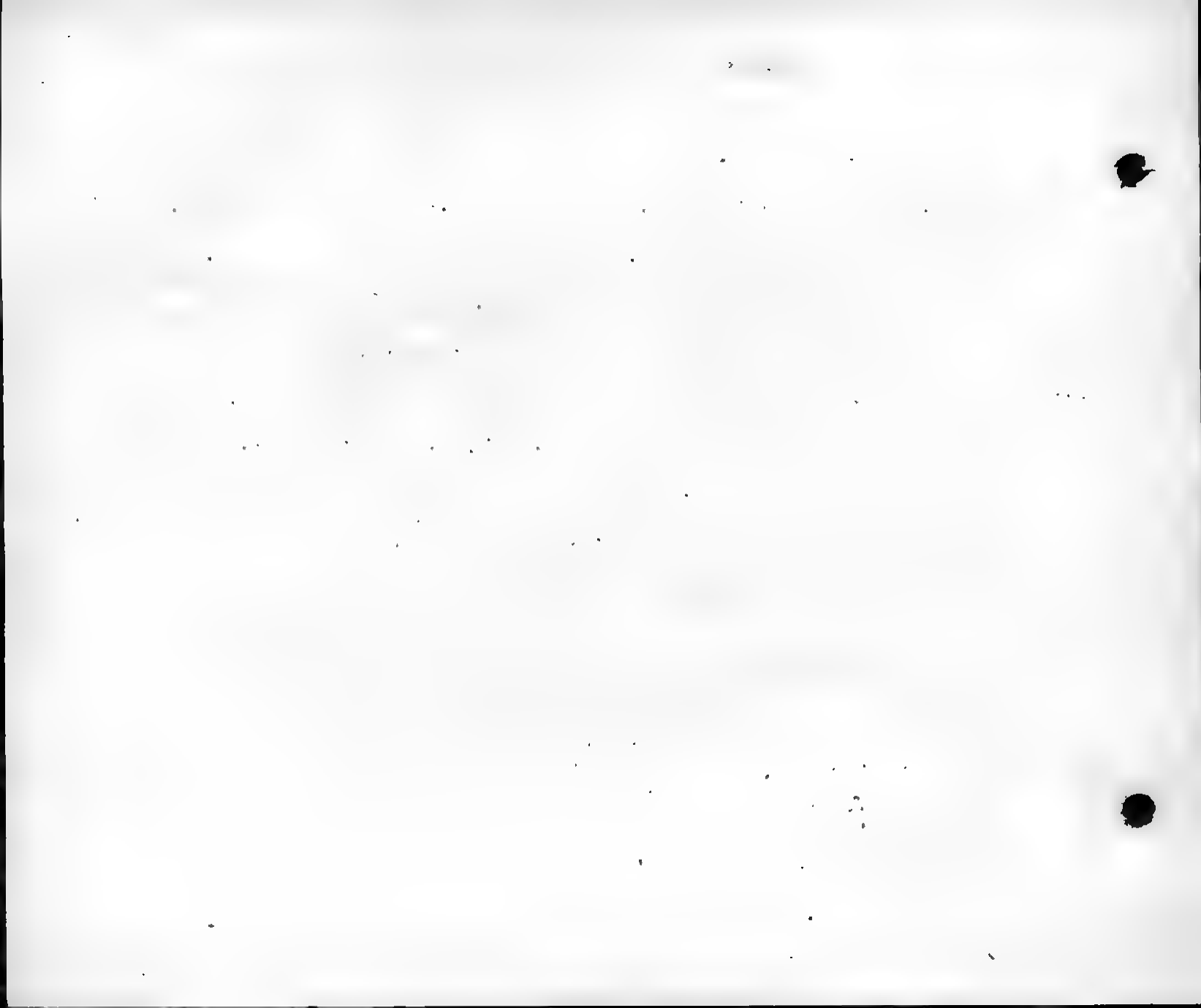
1

Reg. Dist. No.

09984

10008

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 16 Box 240 Ebenezer Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Richardson</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 20, 1873</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Robertson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Dunty</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Harry R. Richardson</u>		Address <u>Rt. 16 Box 240</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senility</u> <u>715X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>General infection Bed sores</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 15, 1959</u> to <u>Sept 12, 1959</u> , that I last saw the deceased alive on <u>Sept 10, 1959</u> , and that death occurred at <u>8 A. M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>5402 Belair Rd. Balto 6 Md.</u> DATE SIGNED <u>Michael J. Grossfield</u>			
ACTUAL SIGNATURE <u>Michael J. Grossfield</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Michael J. Grossfield M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 15, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Chase, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		24a. REC'D BY REGISTRAR <u>SEP 16 59</u>	
ADDRESS <u>7401 Belair Rd.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hase</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

10009

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 27 Days d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (2) d. STREET ADDRESS 716 N. Gay Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELBERT Middle --- Last RICKS		4. DATE OF DEATH Month September Day 20 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 25, 1914
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months 45 Days 45 Hours 45 Min 45	IF UNDER 24 HRS Months 45 Days 45 Hours 45 Min 45
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Nash Co., N. Carolina
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Daniel Ricks	
14. MOTHER'S MAIDEN NAME Leora Todd		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II	
16. SOCIAL SECURITY NO. 243-20-1960		INFORMANT Address Clinical Records VAH, Balto, Md., Ft. Howard Div.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA AND ASPIRATION PNEUMONIA DUE TO SQUAMOUS CELL CARCINOMA, URINARY BLADDER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ACUTE SUPPURATIVE PERITONITIS (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Operations: 9/14/59 1. Ureteroileostomy, bilateral. 2. Cutaneous ileostomy. 3. Ileostomy.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. VA		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 24, 1959 to September 20, 1959 , and that death occurred at 9:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter J. Pijanowski		ADDRESS (Street, city or town, state) VAH, BALTO., MD. FORT HOWARD DIVISION DATE SIGNED 9/22/59	
PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M.D.		VAH, BALTO., MD. FORTHOWARD DIVISION 9/22/59	
22a. BURIAL CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 9/25/59	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		ADDRESS 1808-10 N. Monroe St. Balto Md.	
24a. REC'D BY REGISTRAR SEP 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Filed 9-14-59 at

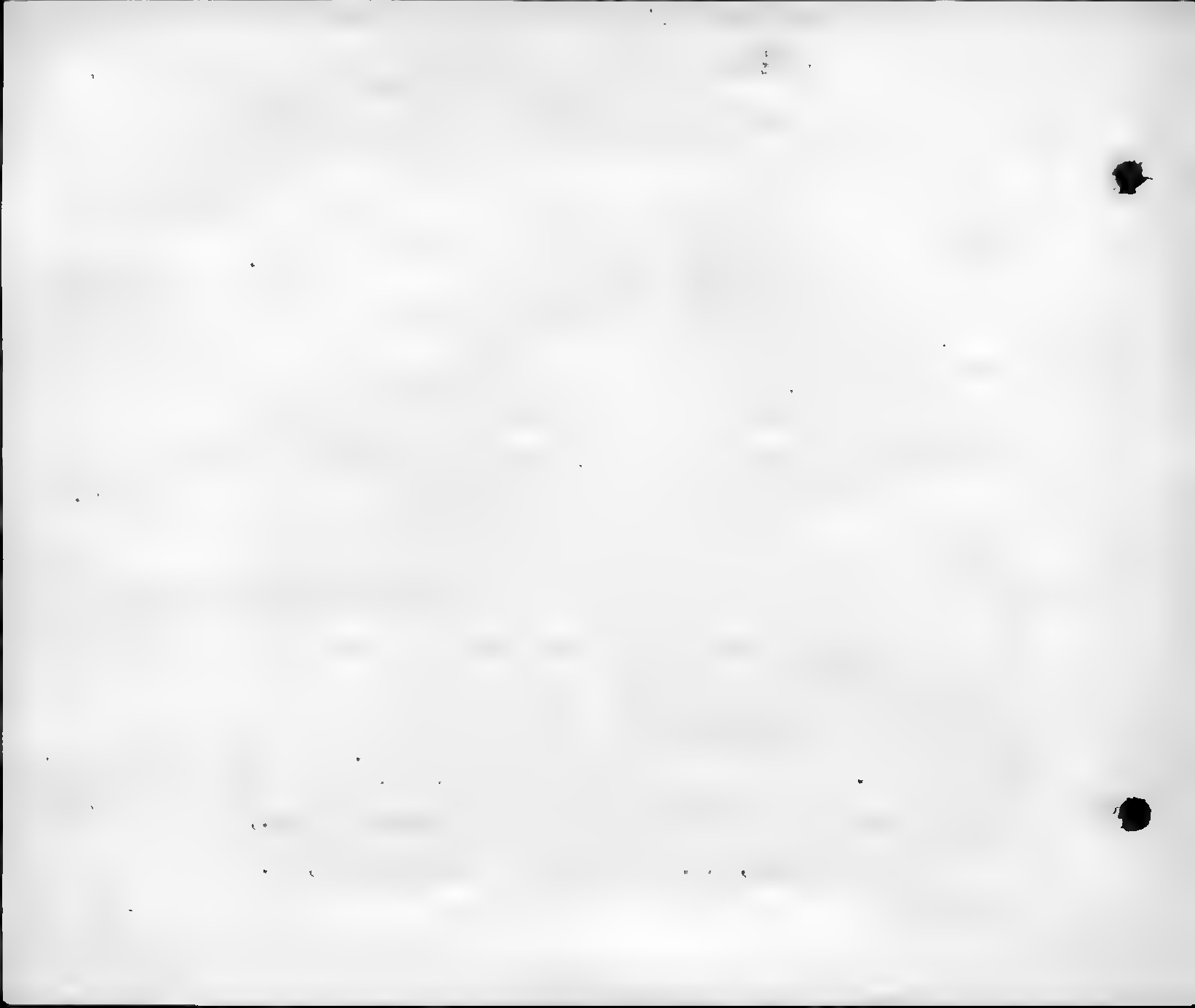
10010

CERTIFICATE OF DEATH

09986

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 PARK DRIVE				e. STREET ADDRESS 101 PARK DRIVE			
3. NAME OF DECEASED (Type or print) First EMMA Middle E. Last RICKTOR				4. DATE OF DEATH Month Sept. Day 5 Year 19 59			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1879	9. AGE (In years last birthday) 79 8/10 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME CHARLES HAUPT				14. MOTHER'S MAIDEN NAME ELIZ.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT John Henry Ricktor - 101 Park Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19 48 , to Sept. 19 59 , that I last saw the deceased alive on Sept. 4 19 59 , and that death occurred at 4:20 AM , from the causes and on the date stated above							
ACTUAL SIGNATURE Leo J. Gaver M.D.				ADDRESS (Street, city or town, state) 1 Malldow Hill Rd.,		DATE SIGNED 9/6/59	
PHYSICIAN'S NAME (Type) Leo J. Gaver, M.D.				Baltimore 22, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8-8-59		22c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		22d. LOCATION (City, town, or county) (State) Woodlawn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Forley Funeral Home, Catonsville, Md.				24a. REC'D BY REGISTRAR DATE SEP 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10011

CERTIFICATE OF DEATH

Reg. Dist. No.

09987

1. PLACE OF DEATH a COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE Maryland b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 10 Days	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 827 Powers Street	
3. NAME OF DECEASED (Type or print) First WALTER Middle H. Last RINEHART		4. DATE OF DEATH Month September Day 5 Year 1959	
5. SEX Ml Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/4/79
9. AGE (In years last birthday) yrs 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Rinehart		14. MOTHER'S MAIDEN NAME Lena Crammer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 10/14/98-2/16/99		16. SOCIAL SECURITY NO. 717-07-8842	
17. INFORMANT Clin. Rec. VAH, Balto, 18, Md. Fort Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION XXXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY INFARCTION DUE TO (c) GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 1 DAY UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 26, 1959 , to September 5, 1959 , and that death occurred at 6:00 P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE Arthur T. Faulk, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED M.D. VAH, BALTO 18, MD. FORT HOWARD DIV. 9/5/59	
PHYSICIAN'S NAME (Type) ARTHUR T. FAULK, M.D.		VAH, BALTO 18, MD. FORT HOWARD DIV.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-9-59	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Chenoweth Funeral Home		24a. REC'D BY REGISTRAR SEP 8 '59	
ADDRESS 36 & Chestnut Avenue Baltimore, Maryland		24b. REGISTRAR'S SIGNATURE Chenoweth	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09988

10012

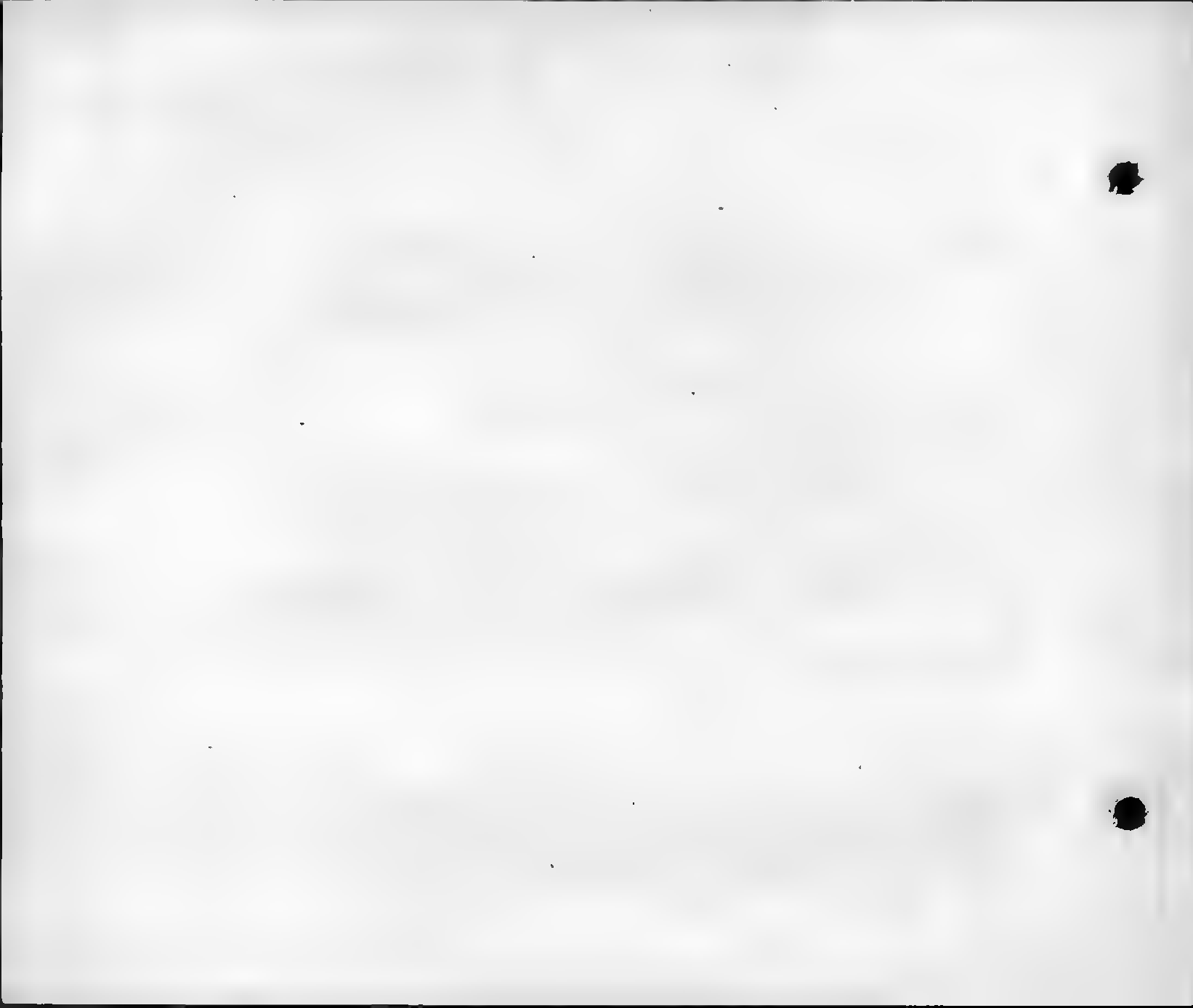
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm sion) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 118 FOREST AVE.		d. STREET ADDRESS 118 FOREST AVE	
3. NAME OF DECEASED (Type or print) MANIE H. ROBERTS		4. DATE OF DEATH SEPT. 3 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 28, 1874
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME HENRY H. DIXON		14. MOTHER'S MAIDEN NAME SUSANA E. LEFTLER	
15. WAS DECEASED EVER IN U S ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT Miss Eleanor Roberts		Address 118 FOREST AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Carditis 44 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vasculen Renal Distensio DUE TO With uremia (c) Senility			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 1958 to Sept 3, 1959 that I last saw the deceased alive on Sept 3, 1959 and that death occurred at 1 P M , from the causes and on the date stated above			
ACTUAL SIGNATURE M. Paul Byerly M.D.		DATE SIGNED 30.33 W North A	
PHYSICIAN'S NAME (Type) M Paul Byerly		Balto 18 med	
22a. BURIAL, CREMATION, REBURY (Specify)	22b. DATE THEREOF 9-6-59	22c. NAME OF CEMETERY OR CREMATORY St Johns Cemetery	22d. LOCATION (City town or county) (State) Ellicott City Ind.
23. FUNERAL DIRECTOR'S SIGNATURE Funeral Home - Catonsville		24a. REC'D BY REGISTRAR SEP 9 59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur A. Thrall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10013

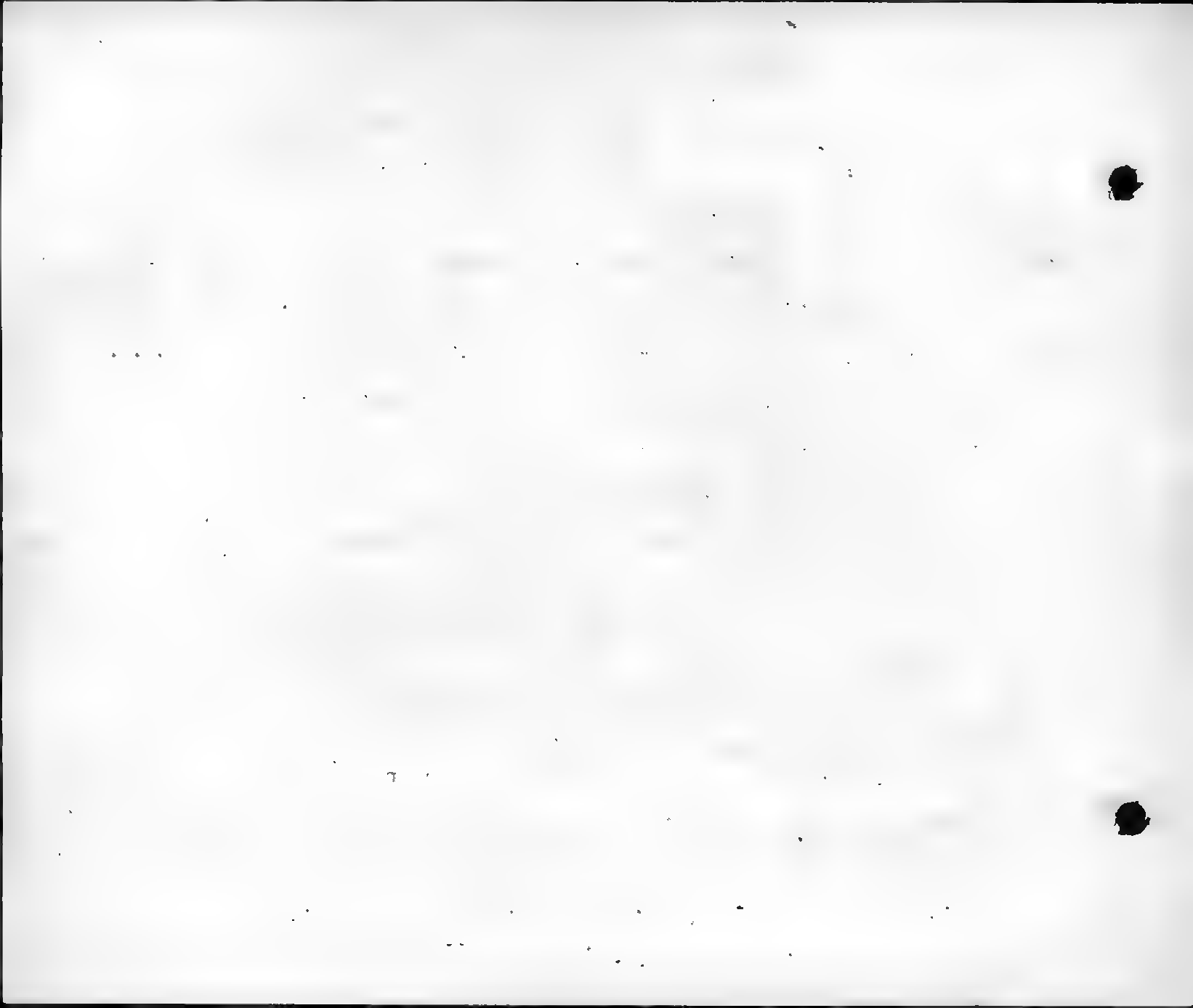
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH Rosewood State Training School a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Res. dence before admission) a. STATE Maryland b. COUNTY City			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland				c. LENGTH OF STAY IN 1b 1 month			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d STREET ADDRESS 6504 Hartwait Street							
3. NAME OF DECEASED (Type or print) First Middle Last Harvey Raymond Robertson				4. DATE OF DEATH Month Day Year 9 18 19 59			
5. SEX Male		6. COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/25/58	
9. AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---				10b KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Harvey Raymond Robertson				14. MOTHER'S MAIDEN NAME Mary Frances Thuman			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) no				16 SOCIAL SECURITY NO. ---			
INFORMANT Rosewood Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 715X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pressure ulcer (thoracic area) DUE TO (c) Arnold Chiari Syndrome							INTERVAL BETWEEN ONSET AND DEATH 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	
20f (City or town) ---				(County) (State)			
21. I certify that I attended the deceased from 8/11/59 19, to 9/18/59 19, that I last saw the deceased alive on 9/18/59 19, and that death occurred at 1:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Owings Mills, Md 9/18/59 DATE SIGNED							
ACTUAL SIGNATURE Harry G. Butler M.D.				PHYSICIAN'S NAME (Type) Owings Mills, Md 9/18/59			
22a BURIAL, CREMATION, REINTERMENT (Specify) Reinterment				22b DATE THEREOF 9-21-59		22c NAME OF CEMETERY OR CREMATORY Gardens of Faith	
22d LOCATION (City, town, or county) Belair				(State) Md.			
23 FUNERAL DIRECTOR'S SIGNATURE James J. Brangulinski				ADDRESS 14072		24a REC'D BY REGISTRAR DATE SEP 22 '59	
24b REGISTRAR'S SIGNATURE Charles R. Hanna							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10014

CERTIFICATE OF DEATH

Reg. Dist. No.

09990

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>HA.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE 14 PINE</u>		d. STREET ADDRESS <u>BROOKLYN</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frederick A. Roder</u>		4. DATE OF DEATH Month Day Year <u>9 10 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-73</u>
9. AGE (In years, last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postmaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WAGGERS W.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John A.</u>		14. MOTHER'S MAIDEN NAME <u>Eva M.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Fam. G. June</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>400.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Crownary Arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>700</u> <u>153 (7)</u> <u>153 (3)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I attended the deceased from <u>7-27</u> , 19 <u>59</u> , to <u>9-10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-10</u> , 19 <u>59</u> , and that death occurred at <u>9:25</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>6209 Frederick Ave. 9-10-59</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		<u>Baltimore 28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9-17-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROCKHILL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO.</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>W. J. - 130 E. Ford Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 14 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. King</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09900

CERTIFICATE OF DEATH

Reg. Dist. No. 09991

1. PLACE OF DEATH a. COUNTY Baltimore Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 14 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 170 Chestnut Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice Rodgers		4. DATE OF DEATH September 19, 1959	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1885
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Clayton, N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henderson Saunders		14. MOTHER'S MAIDEN NAME Lydia Sanders	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Pearl Mc Laughlin		Address 170 Chestnut Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral apoplexy DUE TO (b) Hypertensive arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 21. I certify that I attended the deceased from Sept 18/59 to Sept 19/59 , that I last saw the deceased alive on September 14/59 , and that death occurred at A. M. from the causes and on the date stated above.			INTERVAL BETWEEN ONSET AND DEATH 9/19/59 Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
ACTUAL SIGNATURE J. H. Thomas M.D.		DATE SIGNED 9/22/59	
PHYSICIAN'S NAME (Type) J. H. Thomas		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-23-59	22c. NAME OF CEMETERY OR CREMATORY Harver Hill	22d. LOCATION (City, town, or county) (State) Lanet, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. G. Jackson		24a. REC'D BY REGISTRAR SEP 22 '59	
ADDRESS Funeral Home Inc.		24b. REGISTRAR'S SIGNATURE Arthur A. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10015

CERTIFICATE OF DEATH

09992

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 Clivedon Rd.</u>				d. STREET ADDRESS <u>10 Clivedon Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>JOHNSON S.</u> Last <u>ROMANS</u>				4. DATE OF DEATH Month <u>SEP</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25, 1880</u>		9. AGE (In years last birthday) <u>79</u> yrs.	10. IF UNDER 1 YEAR Months <u>79</u> Days <u>79</u> Hours <u>79</u> Min <u>79</u>	11. IF UNDER 24 HRS Hours <u>79</u> Min <u>79</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Md.</u>	
13. FATHER'S NAME <u>Thomas Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Forman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>no</u>		INFORMANT Address <u>Mr. Alexander Romans - 10 Clivedon Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>79</u> yrs. (c) <u>79</u> yrs. INTERVAL BETWEEN ONSET AND DEATH <u>79 years</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19</u> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19.56</u> to <u>14 Sep. 1959</u> that I last saw the deceased alive on <u>17 Aug. 1959</u> and that death occurred at <u>11:04 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>808 Reisterstown Rd. 14 Sep 59</u>							
ACTUAL SIGNATURE <u>Paul H Royse</u>		M.D. <u>PAUL H ROYSE MD</u>		Pikesville 8, Md.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Crem.</u>		22d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Sicken</u>				24a. REC'D BY REGISTRAR <u>SEP 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Sicken</u>	

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

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VS A15 (4)
15M 9/58



10016

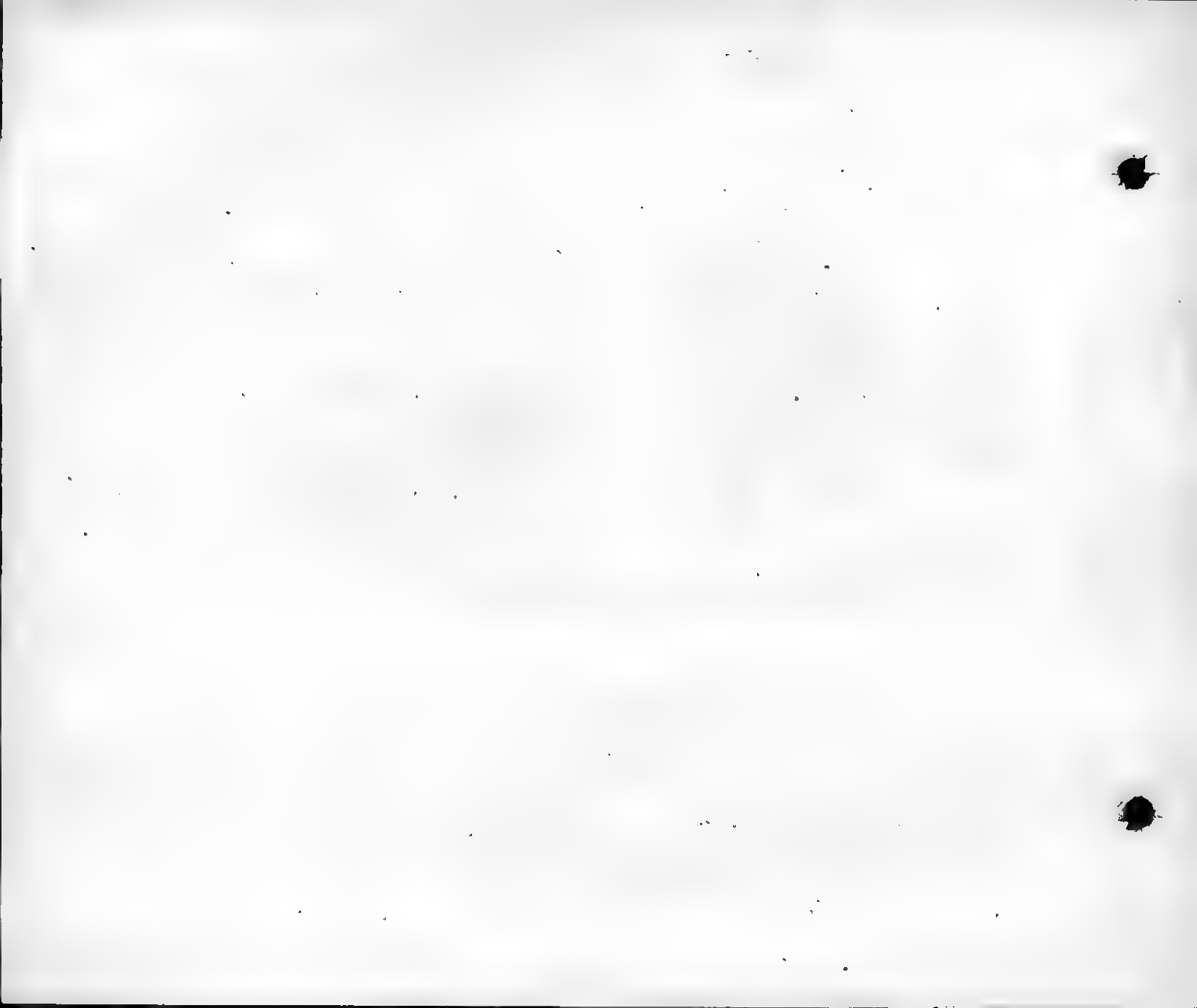
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <i>md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <i>1407 Midvale Ave</i>		d. STREET ADDRESS <i>1407 Midvale Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>Chester</i> Middle <i>Sadler</i> Last		4. DATE OF DEATH Month <i>Sept.</i> Day <i>22</i> Year <i>1959</i>	
5 SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/7/98</i>
9 AGE (In years last birthday) <i>61</i> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dressman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Printing</i>	11 BIRTHPLACE (State or foreign country) <i>md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Joseph Sadler</i>	
14. MOTHER'S MAIDEN NAME <i>Elinizabeth Smith</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>	
16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Marie E. Sadler</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>754.7 Ruptured Aneurysm Pulmonary Artery</i> DUE TO (b) <i>Artery Pulmonary Stenosis + Insufficiency</i> DUE TO (c) <i>Congenital Aneurysm Pulmonary Artery</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>all life</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1/9</i> , 19 <i>57</i> , to <i>9/22</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>8/4</i> , 19 <i>59</i> , and that death occurred at <i>6:45 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Eliot W. Johnson</i>		ADDRESS (Street, city or town, state) <i>3432 Inderside Ave Baltimore 29 Md</i>	
PHYSICIAN'S NAME (Type) <i>ELIOT W. JOHNSON MD</i>		DATE SIGNED <i>9/27/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>9/25/59</i>	<i>Cathedral</i>	<i>Balto. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marie Math + Son</i>		ADDRESS <i>28</i>	
24a. REC'D BY REGISTRAR DATE <i>SEP 28 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

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10017

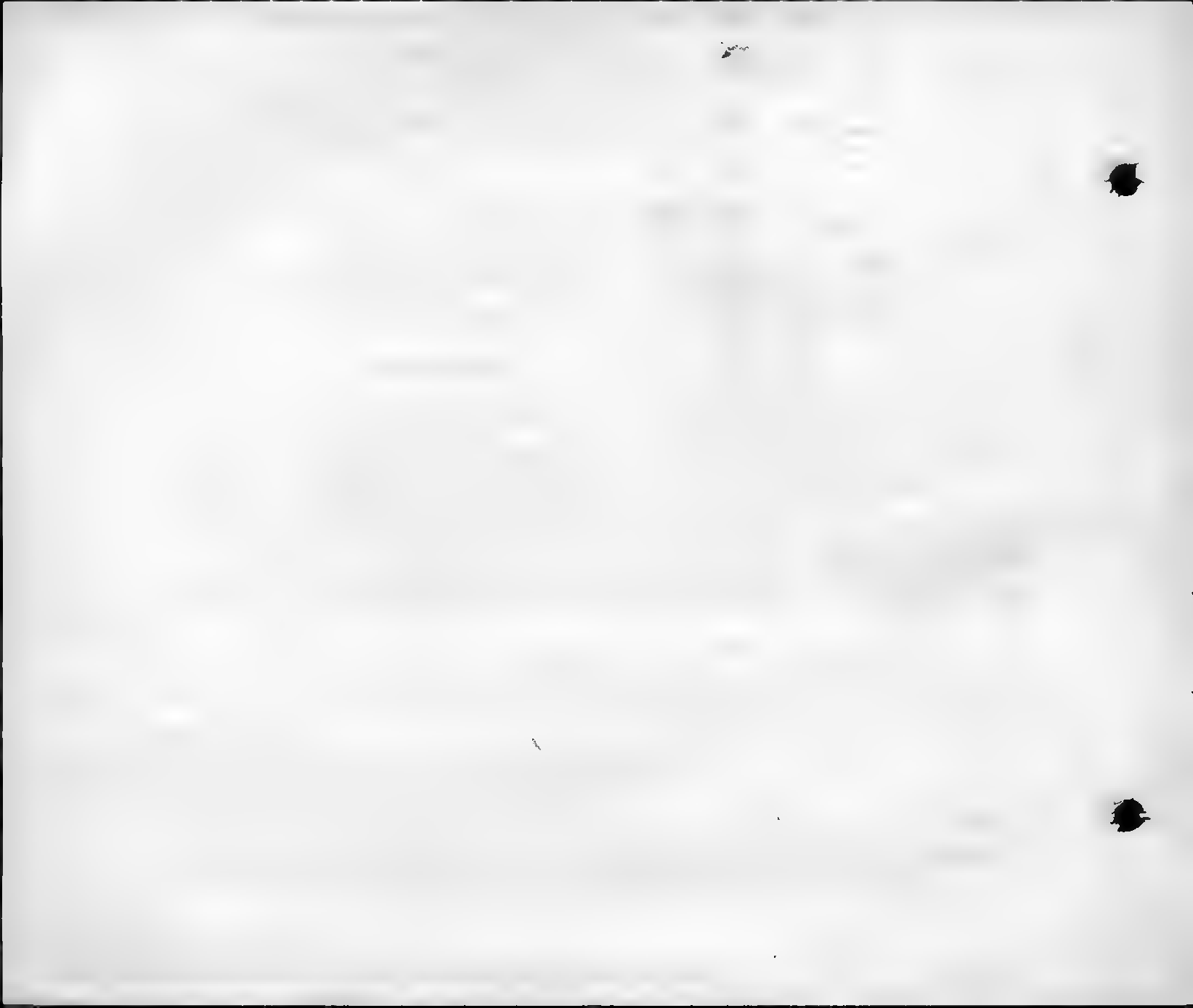
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL OVERLEA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OVERLEA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7703 BELAIR RD</u>		d. STREET ADDRESS <u>7703 BELAIR RD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ADAM WILLIAM SCEPANIAK</u>		4. DATE OF DEATH Month Day Year <u>SEPT 21 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 24 1887</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAVERN OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM SCEPANIAK</u>		14. MOTHER'S MAIDEN NAME <u>MARY NOVAKOWSKI</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>215-40-2242</u>	
17. INFORMANT <u>ANNA G. SCEPANIAK</u>		Address <u>7703 BELAIR RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease, coronary artery disease, 16 yrs.</u> DUE TO (b) <u>coronary occlusion</u> DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>16 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 21, 1959</u> to <u>Sept. 4, 1959</u> that I last saw the deceased alive on <u>Sept 4, 1959</u> , and that death occurred at <u>9:40 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thome Gerson</u> M.D.		ADDRESS (Street, city or town, state) <u>Baltimore, 21, Md</u>	
PHYSICIAN'S NAME (Type) <u>Thome Gerson</u>		DATE SIGNED <u>9/5/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT 8 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST STANISLAUS CEM</u>		22d. LOCATION (City, town, or county) (State) <u>DUNDACK AVE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hubert B... 7110 BELAIR RD</u>		ADDRESS <u>7110 BELAIR RD</u>	
24a. REC'D BY REGISTRAR <u>SEP 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10018

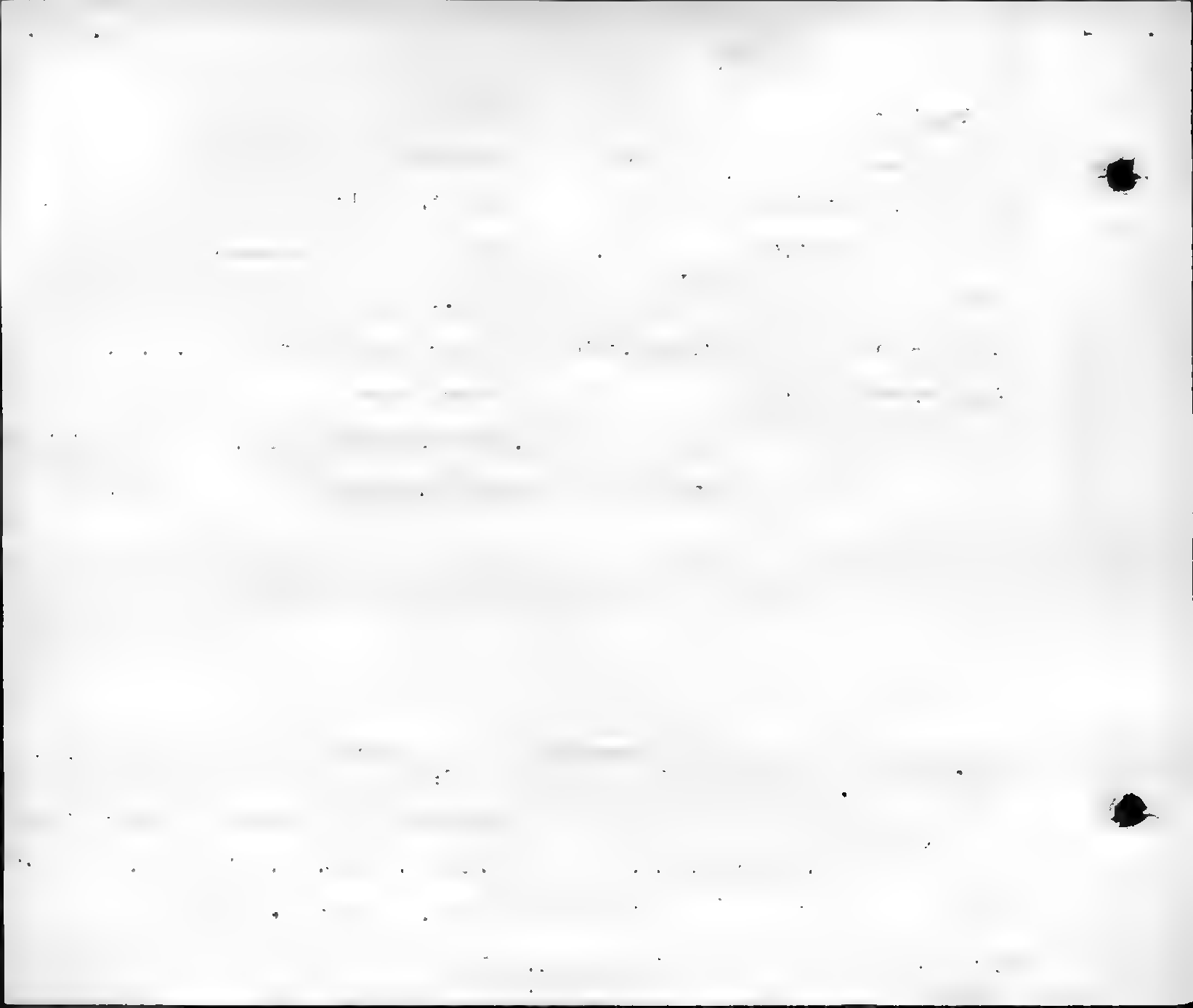
CERTIFICATE OF DEATH

Reg. Dist. No.

09995

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 544 St. Mary's Street			
3. NAME OF DECEASED (Type or print) First SYLVESTER Middle P. Last SCOTT				4. DATE OF DEATH Month September Day 14 Year 1959			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1896	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butler - Cook		10b. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (State or foreign country) Howard County, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Sylvester Scott				14. MOTHER'S MAIDEN NAME Laura Cooper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO WW I			
17. INFORMANT Clin. Records, VAH, Balto. 18, Md. Fort Howard Division				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT (THROMBOSIS) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 12 1959 , to September 14 1959 and that death occurred at 9:20 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John W. Crawford M.D. VAH, BALTO, 18, MD. FT. HOWARD DIVISION 9/14/59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. VAH, BALTO. 18, MD. FT. HOWARD DIV. 9/14/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home				ADDRESS 1631 Druid Hill Ave., Balto Md.		24a. REC'D BY REGISTRAR DATE SEP 17 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10019

CERTIFICATE OF DEATH

Reg. Dist. No.

09996

1 PLACE OF DEATH o. COUNTY <u>Baltimore County</u> <u>19 Harrison St. Essex</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>Maryland</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ivy Hall Nursing Home</u>			c. LENGTH OF STAY IN 1b _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>19 Harrison St. Essex, Md.</u>				d. STREET ADDRESS <u>Long Beach</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>A</u> Last <u>SELFERT</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>21</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6, 1881</u>		9. AGE (In years last birthday) yrs <u>78</u>	IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Harry Kepner</u> Address <u>RD 15 Box 319 Baltimore 20, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerotic Heart Disease, Abnormal Symp.</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____				
20c. TIME OF INJURY Month, Day, Year Hour _____ o. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>55</u> , to <u>current</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/15</u> , 19 <u>59</u> , and that death occurred at <u>7:45</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Joseph J. Cameron</u> M.D. <u>211 - Hickory cot Rd</u> PHYSICIAN'S NAME (Type) <u>JOSEPH J. CAMERON</u> <u>BALTO 4 Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Sept. 21, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East Harrisburg</u>		22d. LOCATION (City, town, or county) (State) <u>Harrisburg, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Book, Inc.</u>				ADDRESS <u>1217 St. Paul St.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 22 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Carlton L. Thomas</u>	

1 2 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
it must be submitted for review to the health department permit. Then please remove further papers. Pages 1 and 2 should be filed with

VS A15 (4
15M 9/58

Picked

10020

CERTIFICATE OF DEATH

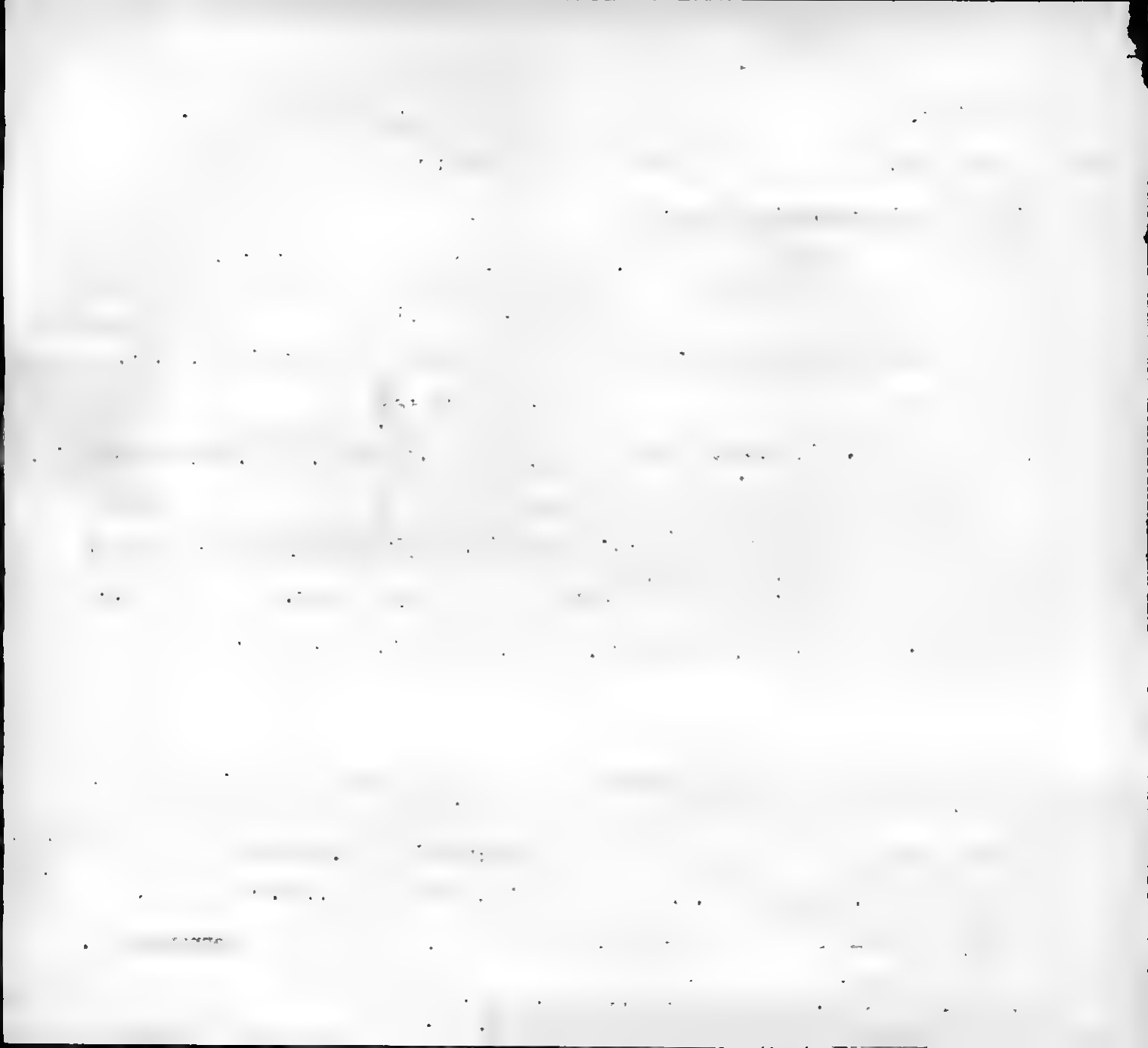
Reg. Dist. No.

09997

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut on Residence before adm.ss on) a. STATE Pennsylvania b. COUNTY Adams	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 32 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle M. Last SHEADS		4. DATE OF DEATH Month September Day 15 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 23, 1895
9. AGE (in years last birthday) yrs. 63		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inventory Control Clerk		10b. KIND OF BUSINESS OR INDUSTRY Book Company	
11. BIRTHPLACE (State or foreign country) Gettysburg, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Peter Sheads		14. MOTHER'S MAIDEN NAME Sarah Wilhide	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 8/30/18-1/21/1918		16. SOCIAL SECURITY NO 204-05-1452	
17. INFORMANT Clin. Records, VAH, Balto. 18, Md. Fort Howard Div.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, RIGHT LUNG XXXX METASTATIC CARCINOMA, RIGHT LUNG, MEDIASTINAL LYMPH NODES, LIVER, SKULL, LEFT 5TH RIB, 5TH LUMBAR VERTEBRA XXXX BRONCHOPNEUMONIA CARDIAC HYPERTROPHY AND MYOCARDIAL SCARRING Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN RECENT UNKNOWN	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS, MARKED, GENERALIZED. CEREBRAL CONGESTION & EDEMA		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that X attended the deceased from August 14, 1959 to September 15, 1959 and that death occurred at 9:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH; BALTO 18, MD. FORT HOWARD DIVISION 9/16/59			
ACTUAL SIGNATURE John W. Crawford		M.D. VAH; BALTO 18, MD. FORT HOWARD DIVISION 9/16/59	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH, BALTO 18, MD., FT. HOWARD DIV.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 9-16-59	22c. NAME OF CEMETERY OR CREMATORY Gettysburg National Cem.	22d. LOCATION (City, town, or county) (State) Gettysburg, Pennsylvania.
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook - Blight, Inc. 6009 Harford Rd.		24a. REC'D BY REGISTRAR SEP 18 59	
24b. REGISTRAR'S SIGNATURE Arthur A. Kras			

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

up by Bender Funeral - Home Carlisle St., Gettysburg, Md. Pa.



10021

CERTIFICATE OF DEATH

Reg. Dist. No.

09998

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. LENGTH OF STAY IN 1b <u>20</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>7916 High Point Rd.</u>		d. STREET ADDRESS <u>7916 High Point Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>G.</u> Last <u>Sheckart</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 13, 1921</u>
9. AGE (In years last birthday) <u>38</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Process Planner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Raymond Sheckart</u>		14. MOTHER'S MAIDEN NAME <u>Jeannie LaBott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> # <u>2</u>		16. SOCIAL SECURITY NO. <u>072-12-5028</u>	
INFORMANT <u>Mrs. Mary Sheckart</u>		Address <u>7916 High Point Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Indigestion with toxic complications</u> <u>159X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic congestive heart failure</u> DUE TO (c) <u> </u>			
INTERVAL BETWEEN ONSET, AND DEATH <u>1 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>56</u> , to <u>Sept.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 27</u> , 19 <u>59</u> , and that death occurred at <u>12 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William H. Hines</u> M.D.		ADDRESS (Street, city or town, state) <u>5100 Harford Rd., Balto., Md.</u> DATE SIGNED <u>10/1/59</u>	
PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 3, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gardens Of Faith</u>		22d. LOCATION (City, town, or county) (State) <u>Trump Mill Rd. Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassaby Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>OCT 2 59</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

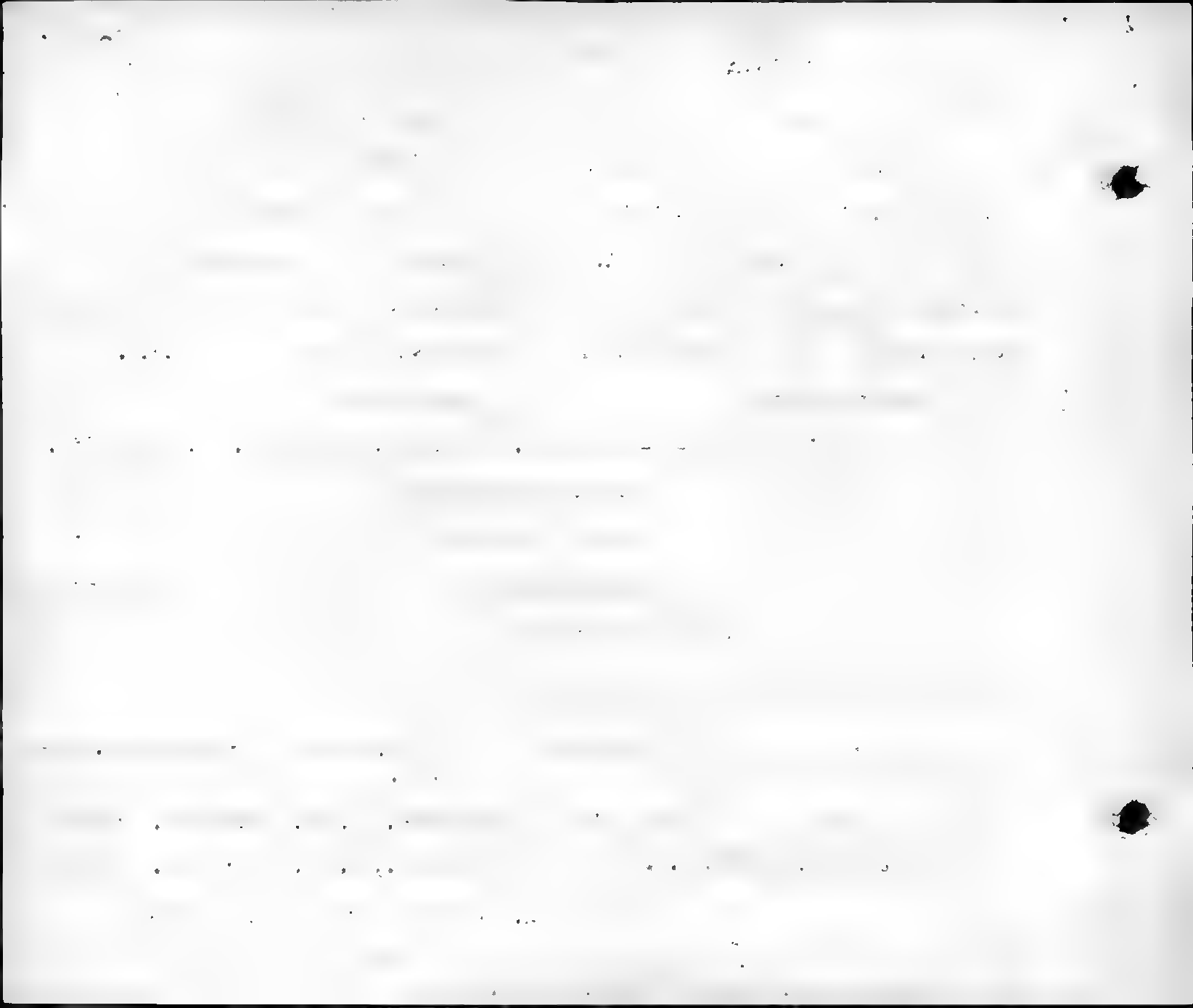
10022

CERTIFICATE OF DEATH

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Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY V	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDGAR Middle L. Last SHUGARS		4. DATE OF DEATH Month September Day 24 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1919
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR: Months 16 Days 16 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Leesburg, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herbert Shugars		14. MOTHER'S MAIDEN NAME Jane Suthers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO 218-05-2944	
17. INFORMANT Clin. Records VAH, Balto 18, Md. Ft. Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CORONARY THROMBOSIS (c) ATHEROSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 16 days 16 days Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Infarction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from September 8, 1959 , to September 24, 1959 , and that death occurred at 5:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE JAMES R. POWDER, M.D.		ADDRESS (Street, city or town, state) VAH Balto., Md. Ft. Howard Div.	
PHYSICIAN'S NAME (Type) JAMES R. POWDER, M.D.		DATE SIGNED 9/24/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-28-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Natl. Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE WM. COOK-BLIGHT, INC. 6009 Harford Rd.		24a. REC'D BY REGISTRAR SEP 29 '59	
ADDRESS WM. COOK-BLIGHT, INC. 6009 HARFORD RD., BALTO., MD.		24b. REGISTRAR'S SIGNATURE Arthur E. Kneiss	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Filed 48 9-8-59 et

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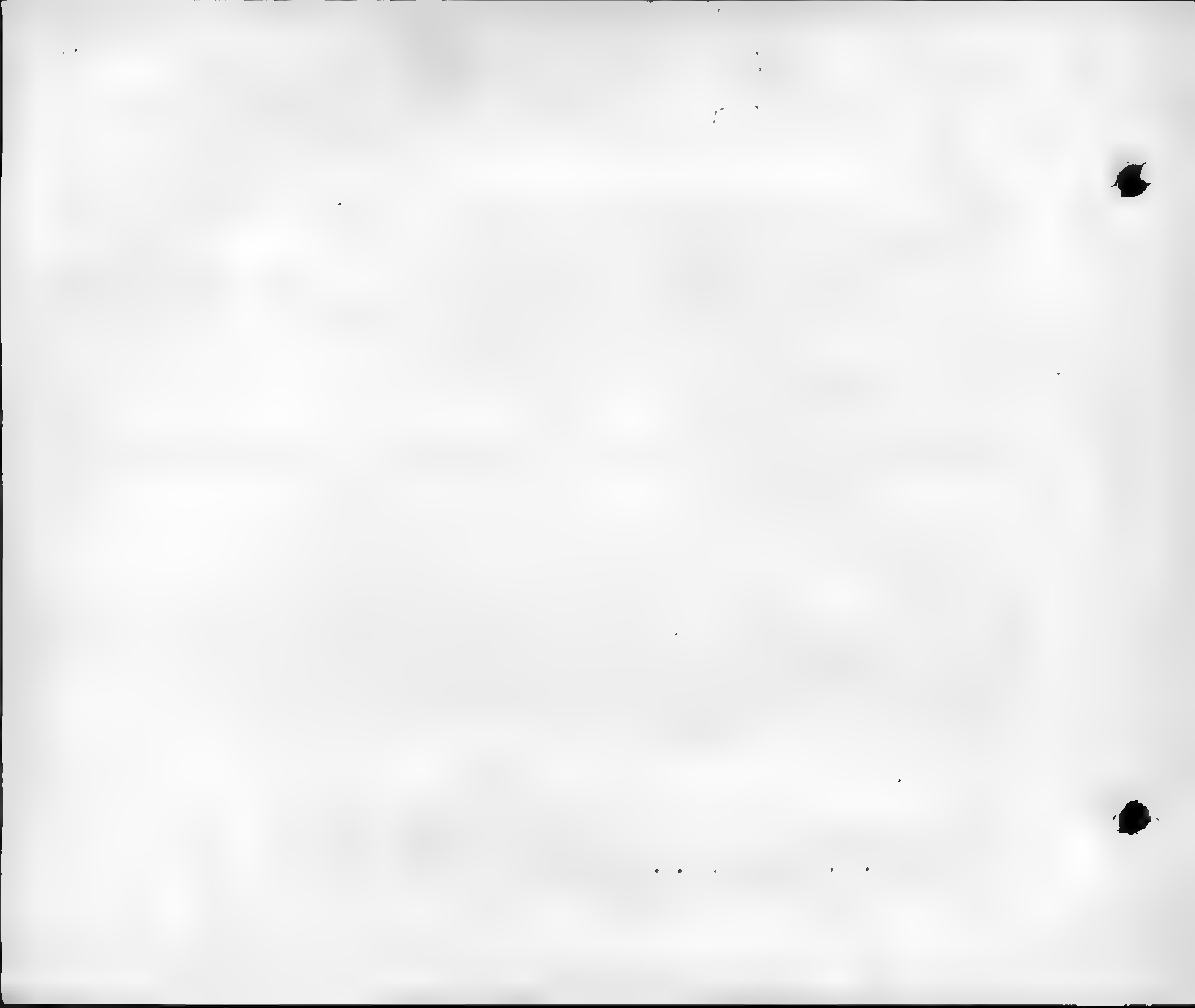
10023

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Balto</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN lb <u>10</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>611 Alleghany av</u>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>611 Alleghany av</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>ANNA CLEMENTINE Smith</u> First Middle Last 4 DATE OF DEATH <u>Sept 2 1959</u> Month Day Year		5 SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH <u>OCT 15 1881</u> 9 AGE (In years last birthday) <u>77</u> yrs IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Easton Md</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert M. Larimore</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Matthews</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <u>no</u> 17. INFORMANT <u>Mrs Dorothy Smith Schloss Stevenson</u> Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.3 Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Metastatic carcinomatosis</u> DUE TO (c) <u>Malignant papilloma of sigmoid (removed October 5, 1957)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>2 years</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized arteriosclerosis HCVD Malnutrition</u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 16</u> , 19 <u>55</u> , to <u>September 2</u> 19 <u>59</u> , that I last saw the deceased alive on <u>September 2</u> , 19 <u>59</u> , and that death occurred at <u>3:20 p. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>18 East Taper Street Baltimore 2, Maryland</u> DATE SIGNED <u>9/3/59</u>			
ACTUAL SIGNATURE <u>B. H. Rutledge</u> M.D.		PHYSICIAN'S NAME (Type) <u>B. H. Rutledge, M.D.</u>	
22a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b DATE THEREOF <u>Sept 4/59</u>	
22c NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d LOCATION (City, town, or county) (State) <u>Pikesville Md</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons Co 4905 York Rd</u> ADDRESS		24a REC'D BY REGISTRAR <u>4 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before adm ssion) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO CITY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MONKTON</u>		c. LENGTH OF STAY IN 1b <u>1 MONKTON, MD. BALTO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BLUE RIDGE RD.</u>		d. STREET ADDRESS <u>BLVD 3519 HICKORY AVE</u>	
3. NAME OF DECEASED (Type or print) <u>Edgar John Smith</u>		4. DATE OF DEATH <u>Sept. 4 1959</u>	
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 25 1896</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SWITCH BOARD OPERATOR UNIVERSITY APT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>W. S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>MC CLELLIAN SMITH</u>		14. MOTHER'S MAIDEN NAME <u>ANNA NEAL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>WM SMITH - 3431 ASH ST.</u>	
17. INFORMANT <u>WM SMITH - 3431 ASH ST.</u>		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio sclerotic Cardio Vascular disease</u> <u>1422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/2/59</u> , 19 <u>59</u> , to <u>9/4/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/3/59</u> , 19 <u>59</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>PATKTON, MD.</u> DATE SIGNED <u>9/5/59</u>	
ACTUAL SIGNATURE <u>A. M. France</u>		PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/7/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MORGAN CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Austin E. Donovan</u> ADDRESS <u>3818 Roland Ave</u>		24a. REC'D BY REGISTRAR <u>SEP 8 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>			



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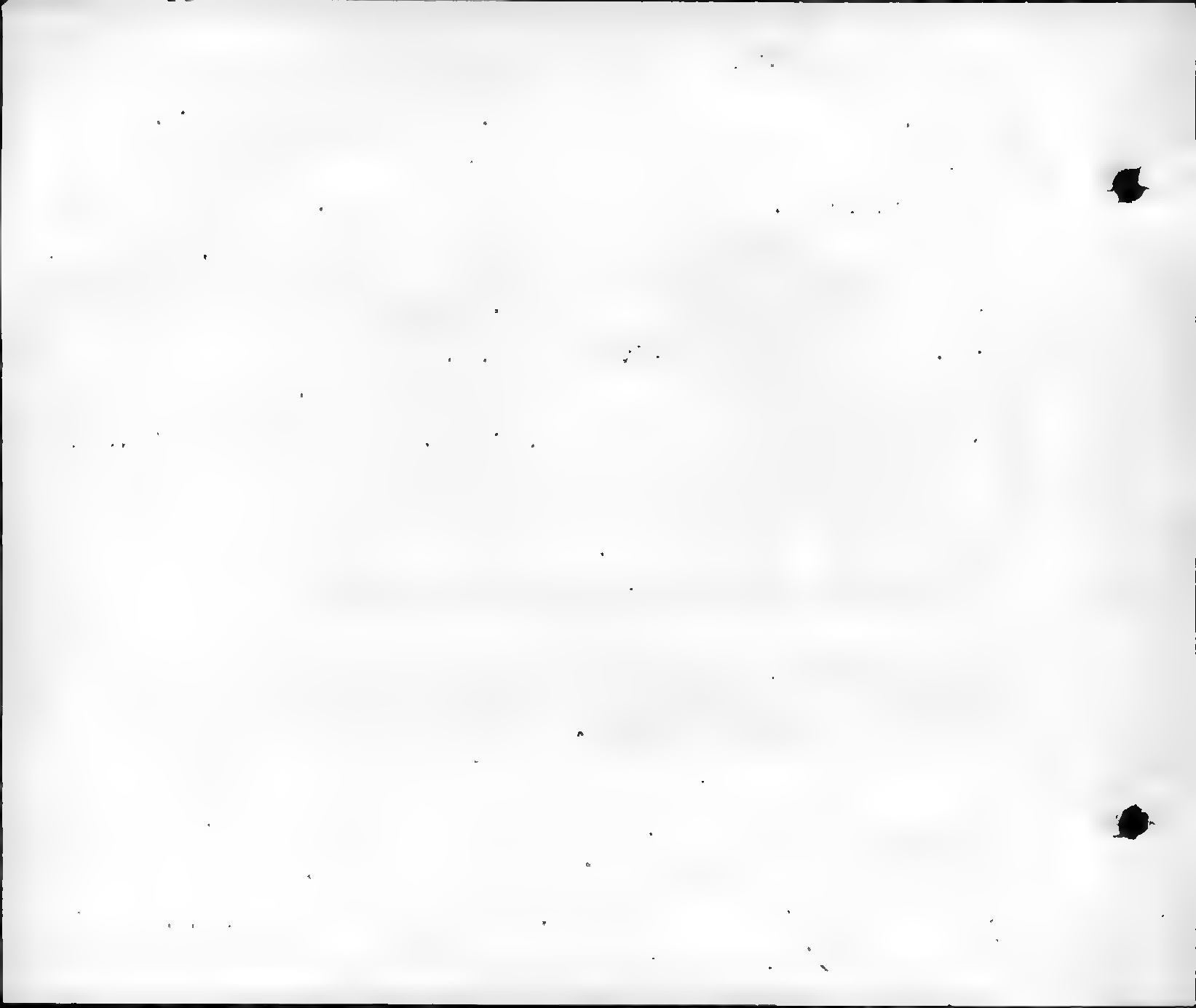
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1249 Francis Ave.				d. STREET ADDRESS 1249 Francis Ave.			
3. NAME OF DECEASED (Type or print) First Nels Middle Smith Last Smith				4. DATE OF DEATH Month Sept. Day 18, Year 19 59			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1889		9. AGE (In years last birthday) 69 yrs	10. IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Army Ordnance Dept.		11. BIRTHPLACE (State or foreign country) N. J.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Anders Smith				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO no		INFORMANT Address Mr. Edwin A. Smith - 1249 Francis Ave., Halethorpe			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO PULMONARY EMBOLISM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CHLORIDE DUE TO (c) CHLORIDE							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/1 , 19 59 to 9/18 , 19 59 , that I last saw the deceased alive on 9/17 , 19 59 , and that death occurred at 4 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1249 Francis Ave., Halethorpe, Md. DATE SIGNED 9/18/59							
ACTUAL SIGNATURE John H. Shaw M.D.				PHYSICIAN'S NAME (Type) John H. Shaw			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/19/59		22c. NAME OF CEMETERY OR CREMATORY Alpine Cem.		22d. LOCATION (City, town, or county) (State) Perth Amboy, N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Baker & Sons - Baltimore				24a. REC'D BY REGISTRAR DATE SEP 21 '59		24b. REGISTRAR'S SIGNATURE Charles E. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10025

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 21 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden 17x	
		d. STREET ADDRESS --	
3. NAME OF DECEASED (Type or print) First HENRY Middle P. Last SNELLING		4. DATE OF DEATH Month September Day 2 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1892
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	
11. BIRTHPLACE (State or foreign country) Somerset Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Palmer G. Snelling		14. MOTHER'S MAIDEN NAME Anna Smullen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 217-03-4451	
17. INFORMANT WW I		Address Clin. Rec. VAH, Balto 18, Md., Fort Howard Division	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE HEMOPTYSIS DUE TO BRONCHOGENIC CARCINOMA, RIGHT LOWER LOBE (b) METASTATIC CARCINOMA, LUNG, MEDIASTINAL LYMPH NODES, (c) PULMONARY INFARCTS, MULTIPLE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. VENOUS INFARCTS, LIVER, RECENT. ATROPHY, ADRENALS UNKNOWN DURATION		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN RECENT
PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

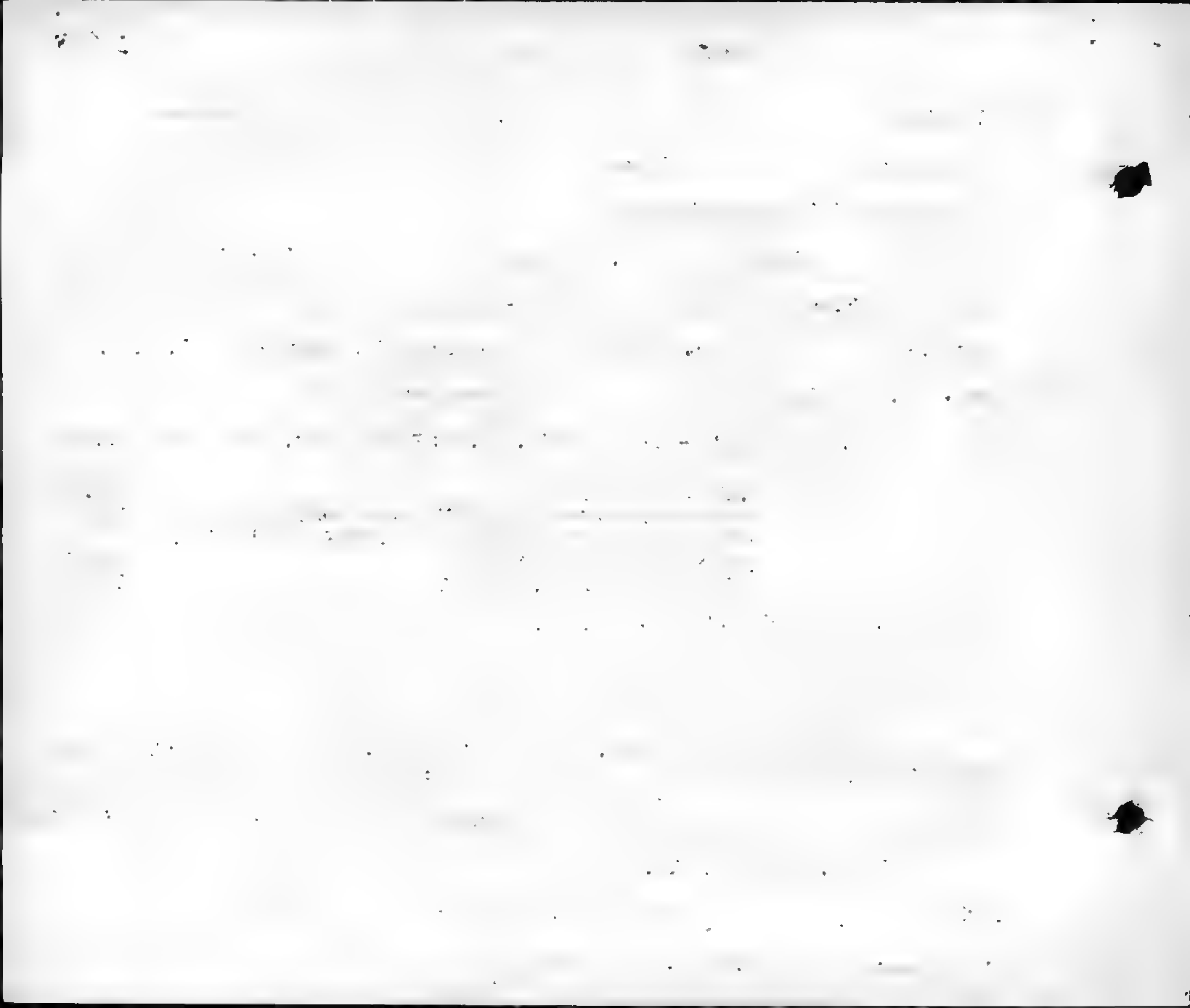
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 12 , 19 59 , to Sept. 2 , 19 59 , and that death occurred at 4:50p M., from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>John W. Crawford</i>	DATE SIGNED 9/3/59
ADDRESS (Street, city or town, state) VAH, BALTO 18, MD FORT HOWARD DIVISION	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/5/59	22c. NAME OF CEMETERY OR CREMATORY Allen Meth. Church Cem/	22d. LOCATION (City, town, or county) (State) Allen, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Funeral Home		24a. REC'D BY REGISTRAR SEP 8 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Haus</i>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10026

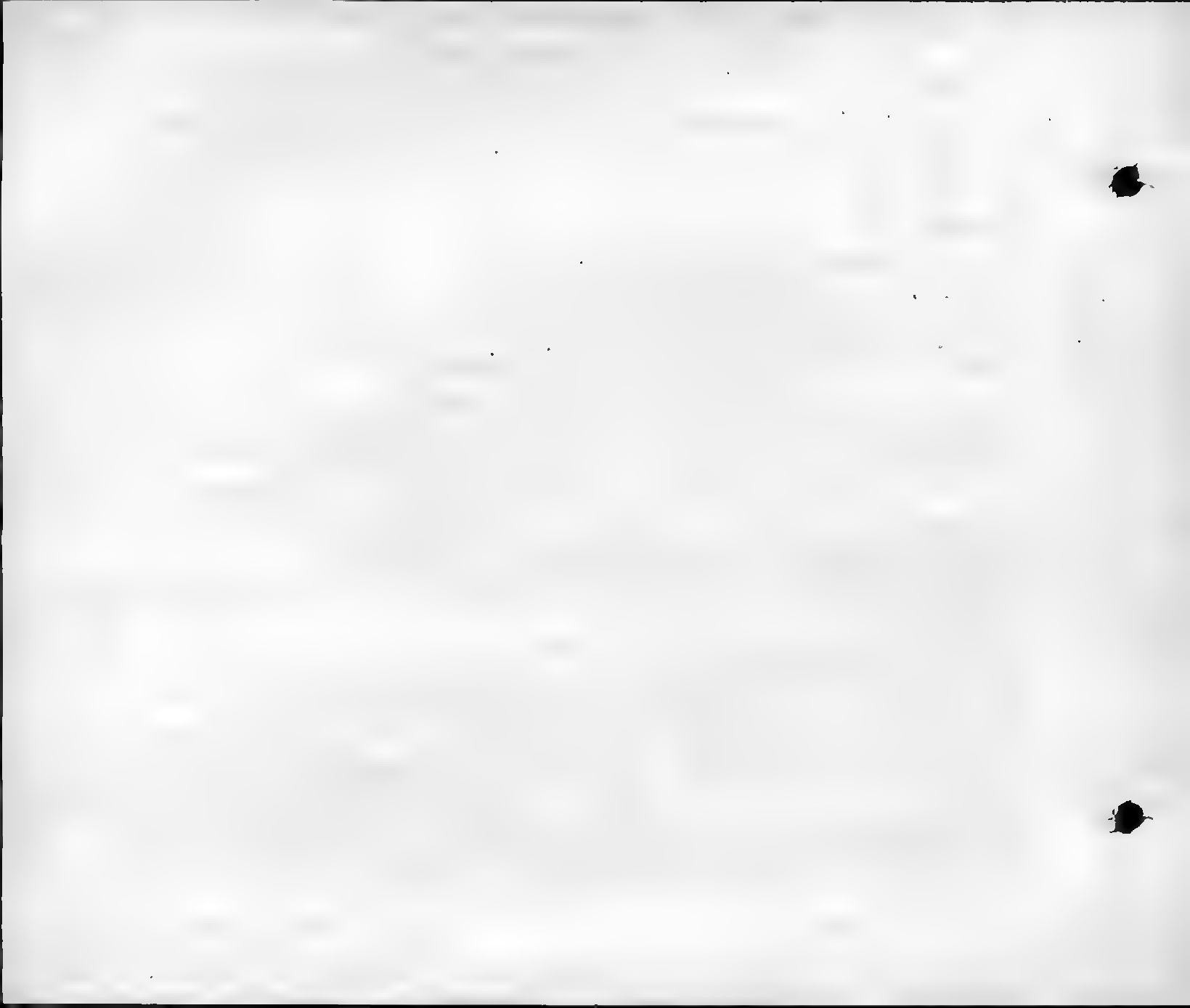
CERTIFICATE OF DEATH

10004

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calonsville</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harrest Haven</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe 51</u>			
				d. STREET ADDRESS <u>1709 Summit Ave</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Morgan P.</u> Middle <u>Stallings</u> Last <u></u>				4. DATE OF DEATH Month <u>September</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 23, 1870</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS Hours <u></u> Min <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night watchman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Robertson Oil Co</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-12-7054</u>		17. INFORMANT <u>Laurel Brown</u> Address <u>1709 Summit Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC CHANGES</u> DUE TO <u>CEREBROVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>NEURIPICAL CIRCULATORY COLLAPSE</u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>9/12</u> , 19 <u>59</u> , to <u>9/14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/14</u> , 19 <u>59</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5800 E. AMERSON AVE</u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u>John A. Shaw</u> M.D.				PHYSICIAN'S NAME (Type) <u>JOHN A. SHAW M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Savage Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Savage, Howard Md.</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ambridge, Inc. 1328 Sulphur Spring Rd</u>				ADDRESS <u></u>		24a. REC'D BY REGISTRAR DATE <u>SEP 8 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10027

CERTIFICATE OF DEATH

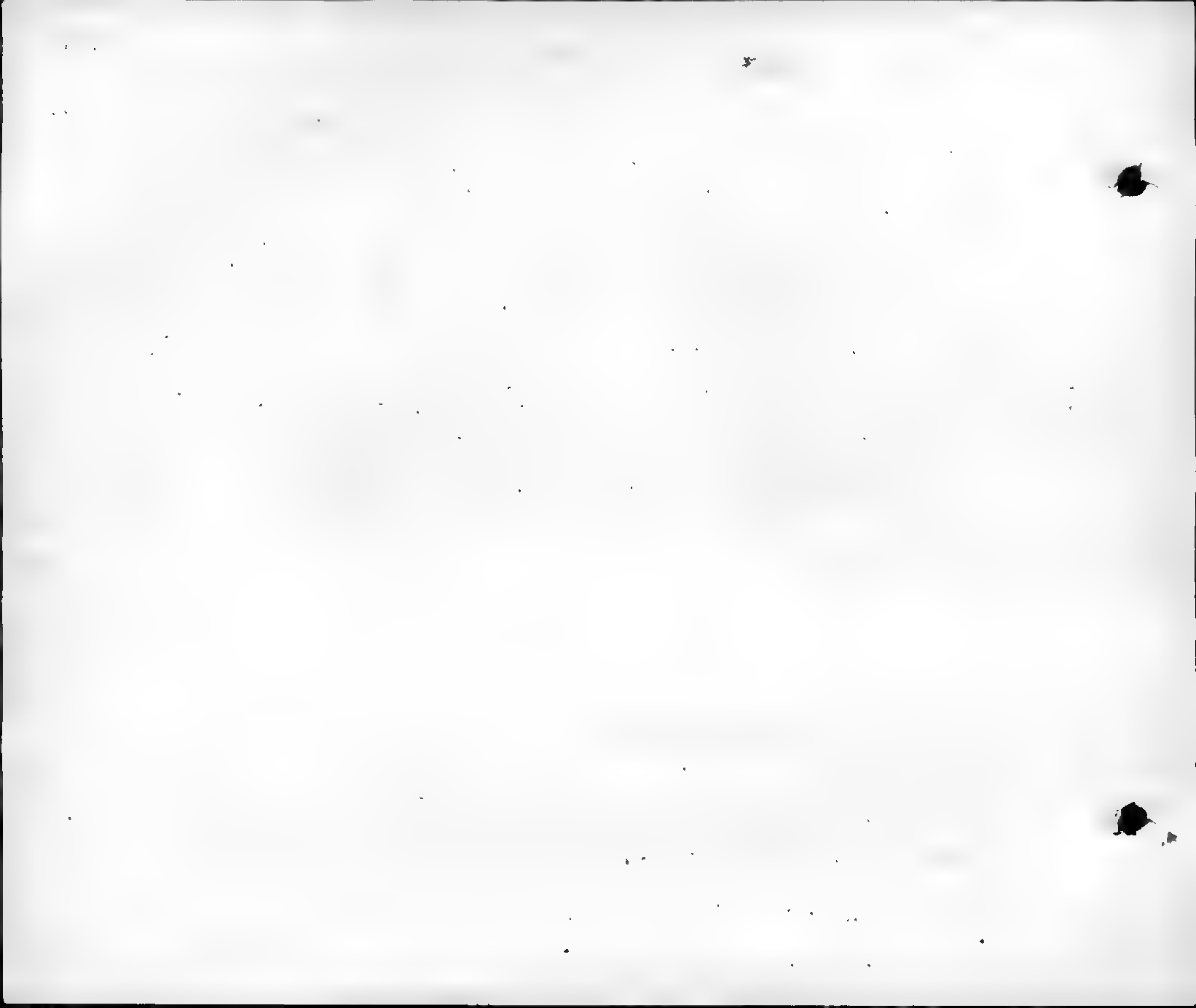
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Towson Conv. Home</u>				d. STREET ADDRESS <u>Vernon Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bessie Bohn Standiford</u>				4. DATE OF DEATH <u>September 26</u> 19 <u>59</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 1, 1882</u>	
9. AGE (In years, months, days) <u>77</u> yrs.		10. IF UNDER 1 YEAR <u>77</u> Months		11. IF UNDER 24 HRS <u>77</u> Days		12. IF UNDER 24 HRS <u>77</u> Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>Saylor Bohn</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Burrell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9/15</u> , 19 <u>59</u> , to <u>9/26</u> , 19 <u>59</u> that I last saw the deceased alive on <u>9/26</u> , 19 <u>59</u> , and that death occurred at <u>1:40 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. Franke</u> M.D.				ADDRESS (Street, city or town, state) <u>PARKTON, MD.</u> DATE SIGNED <u>9/28/59</u>			
PHYSICIAN'S NAME (Type) <u>A. M. FRANK</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Sept 29, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Frederick, Md.</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Hartenstein, New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR <u>SEP 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



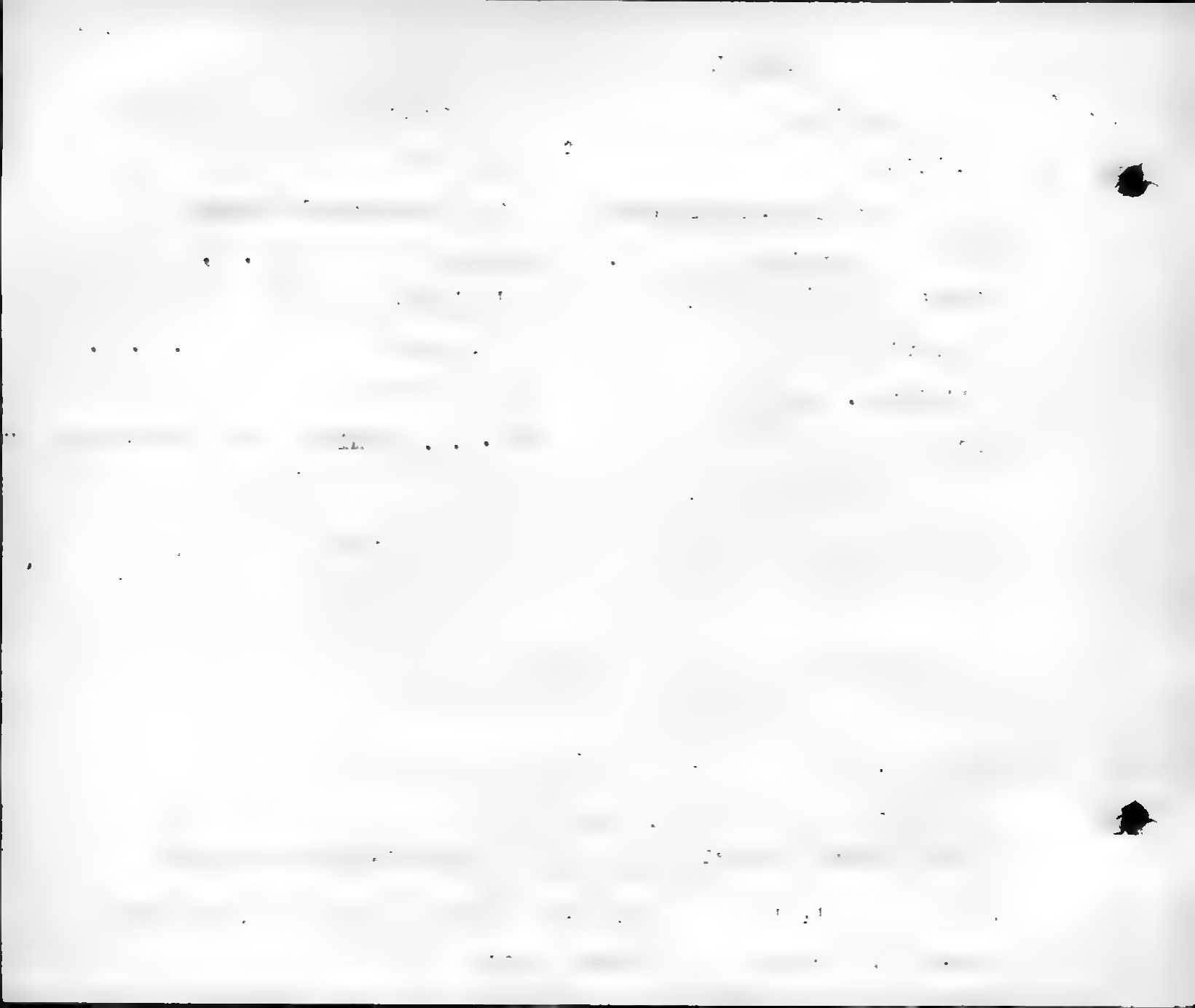
10028
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2001 Monumental Avenue		e. STREET ADDRESS 2001 Monumental Avenue	
3. NAME OF DECEASED (Type or print) First Fannie Middle M. Last Steinberg		4. DATE OF DEATH Month Sept. Day 8, Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11'18'1886
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William J. Beatley		14. MOTHER'S MAIDEN NAME Mary Dickey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. F.A. Schmidt		Address 2001 Monumental Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emaciation & Congestive Failure DUE TO Carcinoma of uterus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. with multiple metastasis (abdominal) DUE TO with multiple metastasis (abdominal) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1 , 19 59 to 9/8 , 19 59 that I last saw the deceased alive on 9/8 , 19 59 , and that death occurred at 12:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>James Frederick</i>		M.D.	
PHYSICIAN'S NAME (Type) James Frederick		1305 Francis Avenue #27	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9'11'59	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
24a. REC'D BY REGISTRAR SEP 11 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10007

10029

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex 21</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex 21</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>315 Savannah Ave</u>		d. STREET ADDRESS <u>315 Savannah Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Galley</u>		4. DATE OF DEATH <u>Sept 12 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u> <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <u>Jan 18 - 1881</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>James Bullock</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u>283813413</u>	
17. INFORMANT <u>Joseph Galley</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory collapse</u> DUE TO <u>Heart failure, chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>5 years</u> <u>stroke</u> <u>feared</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 9, 1959</u> to <u>July 8, 1959</u> , that I last saw the deceased alive on <u>July 8, 1959</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eugene C. Baumann</u>		ADDRESS (Street, city or town, state) <u>413 Eastern Ave Baltimore 21, Md.</u>	
PRINTED NAME (Type) <u>Eugene C. Baumann</u>		DATE SIGNED <u>9-13-59</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>9-16-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenfield Cemetery</u>	22d. LOCATION (City town, or county) (State) <u>Essex 21 Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Baumann</u>		ADDRESS <u>1407 Eastern Ave</u>	
24a. REC'D BY REGISTRAR <u>SEP 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10030

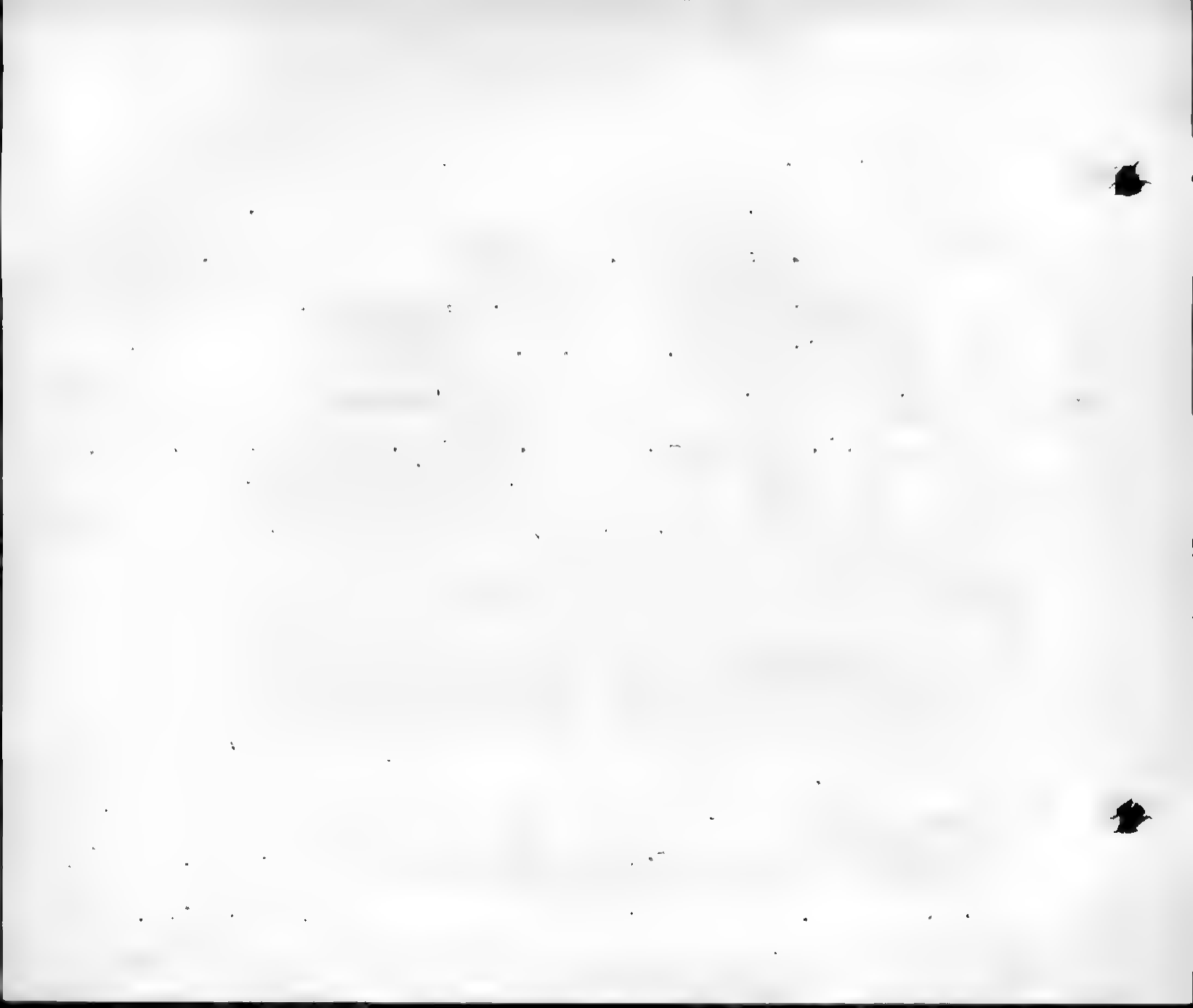
CERTIFICATE OF DEATH

10008

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River		c. LENGTH OF STAY IN 1b 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1506 Dornton Ave.		e. STREET ADDRESS 1506 Dornton Ave.	
3. NAME OF DECEASED (Type or print) First Lester Middle P. Last Taylor		4. DATE OF DEATH Month Sept. Day 23 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1925
9. AGE (In years last birthday) 33 yrs		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	11. IF UNDER 24 HRS Months 3 Days 3 Hours 3 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronic Technician		10b. KIND OF BUSINESS OR INDUSTRY A.T.&T. Tele. Co.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Taylor		14. MOTHER'S MAIDEN NAME Lillie Bloxom	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. W. # 2 218-20-9183	
17. INFORMANT Mrs. Phyllis M. Taylor		Address 1506 Dornton Ave. 20	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 190.9 DUE TO Metastatic CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malignant Melanoma (c) 2 yrs.		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1958 , 19 Sept. 23, 1959 , that I last saw the deceased alive on Sept. 23, 1959 , and that death occurred at 9:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John E. Gessner		DATE SIGNED 701 EASTERN AVENUE BALTIMORE 21 Md.	
PHYSICIAN'S NAME (Type) John E. GESSNER		ADDRESS (Street, city or town, state) BALTIMORE 21 Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 25, 1959	22c. NAME OF CEMETERY OR CREMATORY Downing's	22d. LOCATION (City, town, or county) (State) Oak Hill, Virginia.
23. FUNERAL DIRECTOR'S SIGNATURE Gessner Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR SEP 25 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician on. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10009

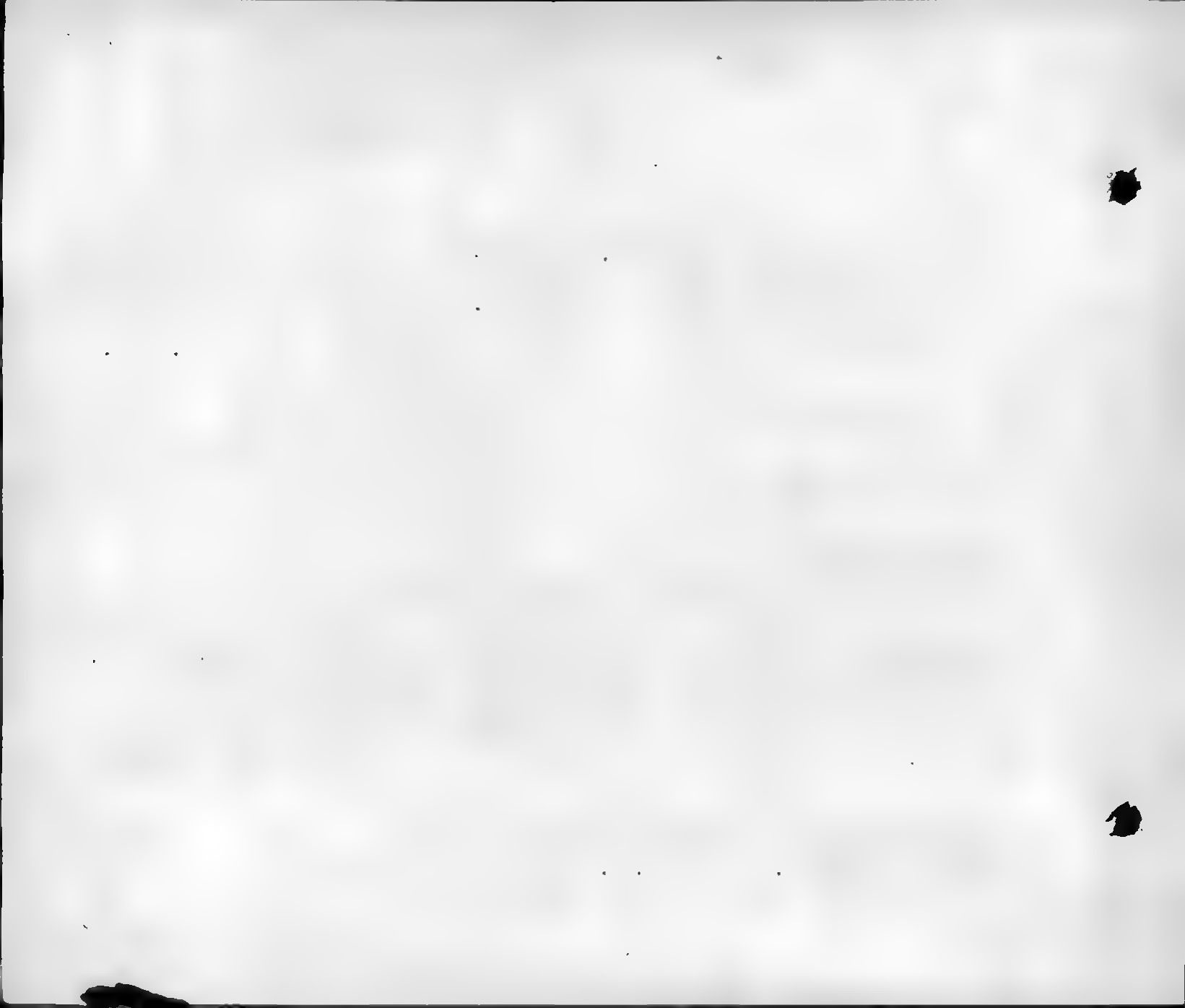
Reg. Dist. No

10031

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be turned to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institutional Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Anne Arundel</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c LENGTH OF STAY IN 1b <u>2mth27dys</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Basadena, Maryland</u>	
3. NAME OF DECEASED (Type or print) First <u>Owen</u> Middle <u>E.</u> Last <u>Thomas</u>		4 DATE OF DEATH Month <u>September</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16, 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address <u> </u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u>			
422.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease</u>			
(c) <u>Generalized arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of right femur</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>on 8-27-59 pt. fell in bathroom sustaining fracture of right femur</u>	
20c. TIME OF INJURY Month, Day, Year <u>9:30 PM 8-27-59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hospital</u>	20f. (City or town) (County) (State) <u>Catonsville 28, Maryland</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Geo S. M. Kieffer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9-1-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	22b. DATE THEREOF <u>9.5.59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>	22d. LOCATION (City, town, or county) (State) <u>Bethesda, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McClary - 130 E. Fear Ave.</u>		24a. REC'D BY REGISTRAR <u>DA SEP 3 '59</u>	
ADDRESS <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinas</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10032 CERTIFICATE OF DEATH

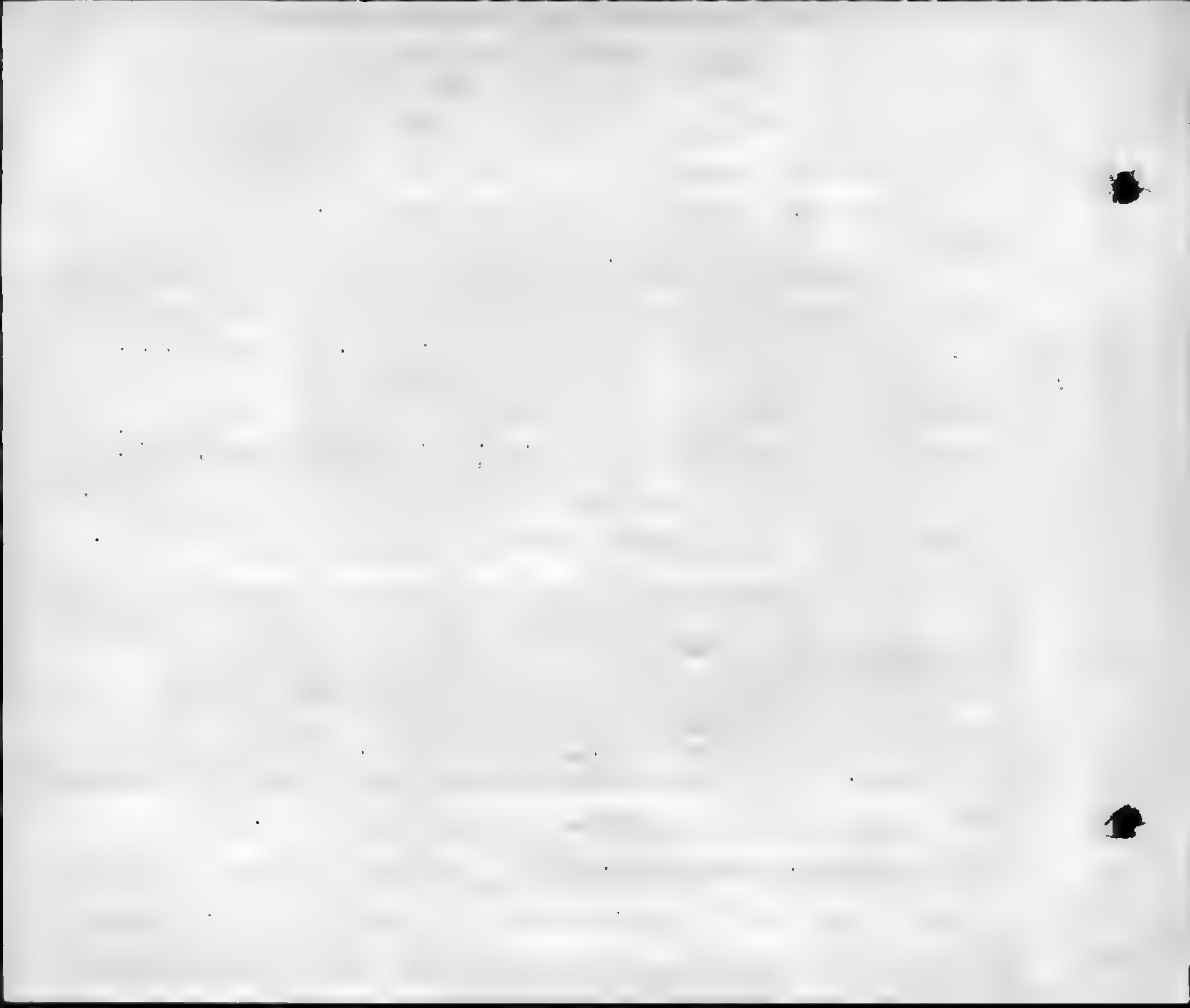
Reg. Dist. No.

10010

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton 4, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1001 Malvern Ave.		d. STREET ADDRESS 1001 Malvern Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle Bryant Last Tompkins		4. DATE OF DEATH Month September Day 17 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/3/06
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Osteopath		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Somerset, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Everett Tompkins		14. MOTHER'S MAIDEN NAME Emma Grace Bryant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-38-6296	
17. INFORMANT Son. St. R.D. Tompkins		Address 445 Sunset Pk. Novato, Calif.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Subungual melanoma, left fifth toe DUE TO (c) 1 yr.			INTERVAL BETWEEN ONSET AND DEATH 6 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced metastatic disease - melanoma			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from Feb. 17, 1959 , to Sept. 17, 1959 , that I last saw the deceased alive on Sept. 17, 1959 , and that death occurred at 4:55 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 E. Biddle St., Balto. 2, Md. DATE SIGNED 9/17/59			
ACTUAL SIGNATURE Robert G. Chambers		M.D. 15 E. Biddle St., Balto. 2, Md.	
PHYSICIAN'S NAME (Type) Robert G. Chambers, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 9/21/59	22c. NAME OF CEMETERY OR CREMATORY Greenmount	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Townson, Inc. - Townson, Md.		24a. REC'D BY REGISTRAR DATE SEP 21 1959	24b. REGISTRAR'S SIGNATURE Arthur J. Kane

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10033

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7903 Ellenham Ave				d. STREET ADDRESS 7903 Ellenham Ave			
3. NAME OF DECEASED (Type or print) First Middle Last AUGUST FREDERICK TRUMPLER				4. DATE OF DEATH Month Day Year Sept. 18, 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager -Salesman		10b. KIND OF BUSINESS OR INDUSTRY Retail Jewellery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Maximilliaon L. Trumpler				14. MOTHER'S MAIDEN NAME Susan L. Leutner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO 216-01-2453		17. INFORMANT Ruth J. Trumpler-7903 Ellenham Ave.			
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensative Cardio Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Jan 12 , 19 56 , to Sept 18 , 19 59 , that I last saw the deceased alive on Sept 18 , 19 59 , and that death occurred at 8:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6805 York Rd Baltimore 12 DATE SIGNED 9/19/59 ACTUAL SIGNATURE Laurence C. Post M.D. PHYSICIAN'S NAME (Type) LAURENCE C. Post							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 22/59		22c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Gardens		22d. LOCATION (City, town, or county) (State) Balto County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. Towson, Maryland				24a. REC'D BY REGISTRAR DATE SEP 21 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Knease	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3/10

1 ANKEN
22 X
21

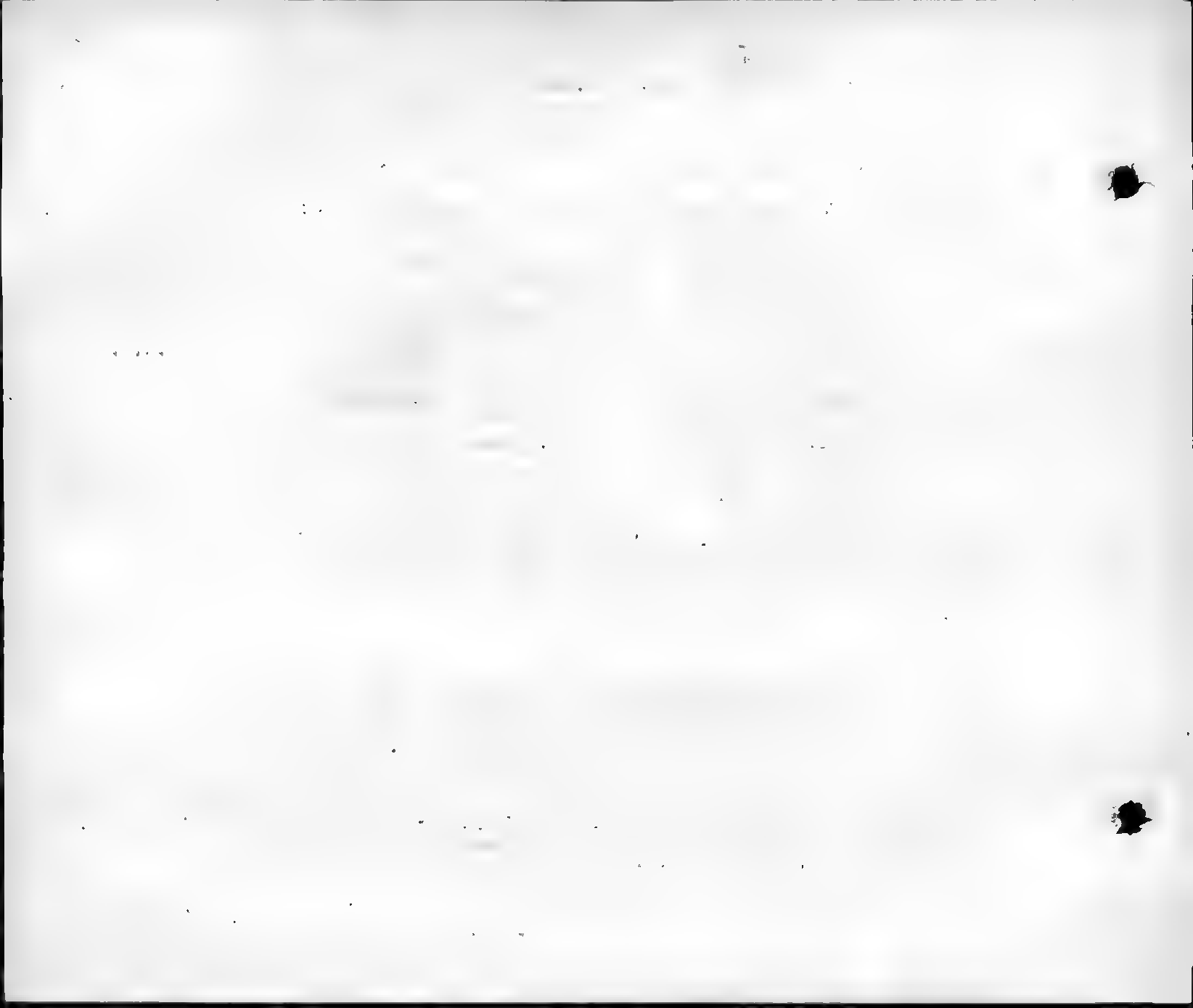
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10012
Item 18 Film 249 10-7-59 ams										10034
CERTIFICATE OF DEATH										Reg. Dist. No.
1 PLACE OF DEATH <u>Rosewood State Training School</u>					2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)					
a. COUNTY <u>Baltimore</u> MARYLAND					a. STATE <u>Maryland</u> b. COUNTY <u>City</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 16, Maryland</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>					d. STREET ADDRESS <u>2833 Presbury Street</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First <u>Alisa</u> Middle <u>Ann</u> Last <u>Vaughns</u>					Month <u>SEPTEMBER</u> Day <u>27</u> Year <u>1959</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/27/57</u>		9. AGE (In years last birthday) <u>2</u> yrs		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>John Henry Vaughns</u>					14. MOTHER'S MAIDEN NAME <u>Ruth Bella Banks</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>—</u>					INFORMANT <u>Rosewood Records</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>Aspiration of stomach contents</u> DUE TO (c) <u>no external condition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>External hydrocephalus</u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
					20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>Sept 26, 1958</u> to <u>Sept 27, 1959</u> that I last saw the deceased alive on <u>9/27/59</u> and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>Edward J. Mathews</u> M.D.					ADDRESS (Street, city or town, state) <u>Rosewood State Training School Box 188 Owings Mills, Maryland</u>					DATE SIGNED <u>9-27-59</u>
PHYSICIAN'S NAME (Type) <u>Edward J. Mathews, M.D.</u>										
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>					22b. DATE THEREOF <u>9-30-59</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Not cemetery</u>
					22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy O. Williams</u>					24a. REC'D BY REGISTRAR DATE <u>SEP 28 '59</u>					24b. REGISTRAR'S SIGNATURE <u>Christina</u>

VS A15 (4)
15M 9/58



10035

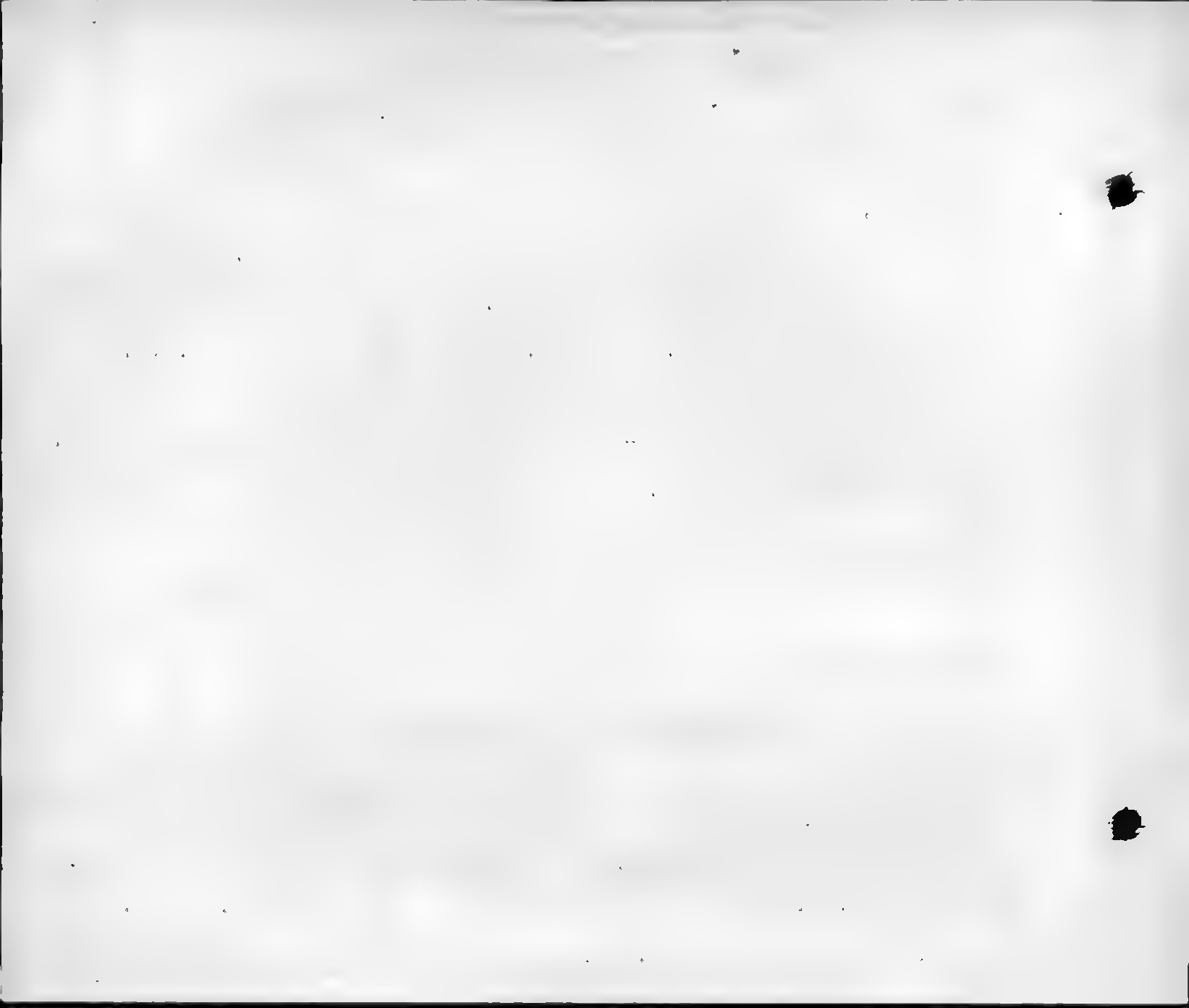
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Inverness		c. LENGTH OF STAY IN 1b 24 yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Inverness, Dundalk		d. STREET ADDRESS 102 Bayside Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) Residence, 102 Bayside Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Raymond Middle Henry Last Vogel		4. DATE OF DEATH Month Sept. Day 23 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1903
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	
11. BIRTHPLACE (State or foreign country) Chicago, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gustav Vogel		14. MOTHER'S MAIDEN NAME Katherine Ryan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Army & 1919 to 1936		16. SOCIAL SECURITY NO. 6213-07-5422	
17. INFORMANT Mrs. Henrietta Vogel		Address 102 Bayside Dr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardi-vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH 11 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-19 , 1948 , 9-23 , 1959 , that I last saw the deceased alive on 9-22 , 19 59 , and that death occurred at 9:57 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE M B Davis M.D. 6800 MORNINGTON RD		PHYSICIAN'S NAME (Type) Melvin E. Davis M.D. Dundalk Md. 9/24/59	
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF 9-26-1959	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Eastern Ave. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda		ADDRESS 7922 Wise Ave. 22, Md.	
24a. REC'D BY REGISTRAR DATE SEP 28 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Fenn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10036

CERTIFICATE OF DEATH

Reg. Dist. No.

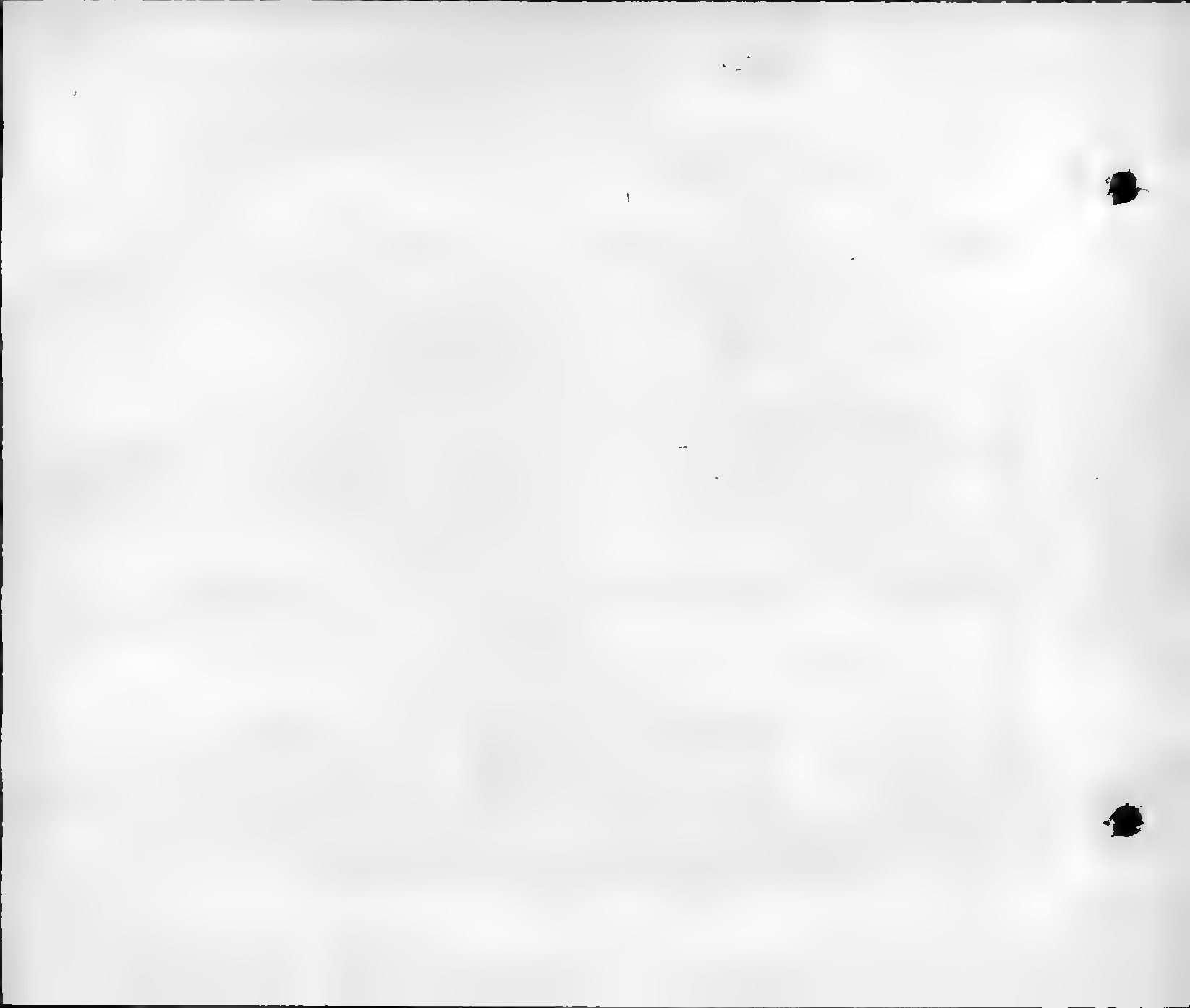
10014

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 81 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 430 Main Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
3. NAME OF DECEASED (Type or print) First Samuel Middle Joseph Last Vondersmith		4. DATE OF DEATH Month September Day 17 Year 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 19 1873
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Balto Transit	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel S Vondersmith		14. MOTHER'S MAIDEN NAME Maria Louise Humphreys	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-07-8652	
17. INFORMANT H J Vondersmith		Address Reisterstown Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocarditis - chronic decompensation DUE TO hypertension - arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension - arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 months		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-39 to 11-17 , 19 59 , that I last saw the deceased alive on 10-17-59 , 19 59 , and that death occurred at 10 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James L. Saffell M.D.		DATE SIGNED 9-19-59	
PHYSICIAN'S NAME (Type) James C. Saffell		ADDRESS (Street, city or town, state) Reisterstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 21 1959	22c. NAME OF CEMETERY OR CREMATORY Reisterstown Meth Cem	22d. LOCATION (City, town, or county) (State) Reisterstown Md
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Berryman & Sons		24a. REC'D BY REGISTRAR DATE SEP 22 '59	
ADDRESS Reisterstown Md		24b. REGISTRAR'S SIGNATURE Curtis L. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

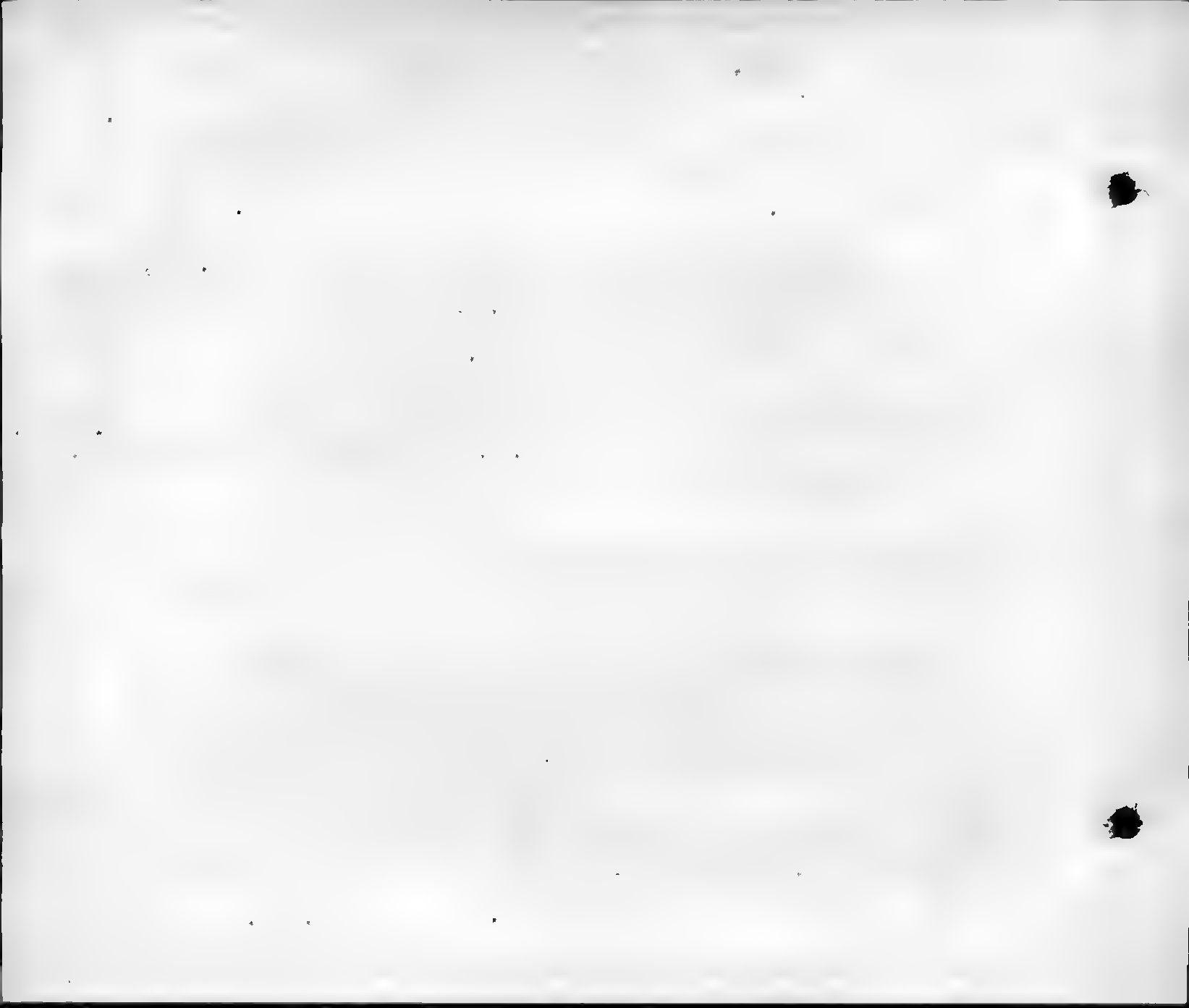
10037

CERTIFICATE OF DEATH

10015

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stoneleigh		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stoneleigh - Baltimore 12,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 606 Stoneleigh Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle MAYNARD Last WAGNER		4. DATE OF DEATH Month Sept. Day 3 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 6, 1904
9. AGE (In years last birthday) 55 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY self employed	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Henry Wagner		14. MOTHER'S MAIDEN NAME Annie Elizabeth Knoblock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. C. Serena Wagner - 606 Stoneleigh Rd.		Address Balto. 12, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4 1/2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis 3 yrs. (c)			INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 15, 1959 to Sept 3, 1959 , that I last saw the deceased alive on Aug 29, 1959 , and that death occurred at 1 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11 W 29th St - Baltimore DATE SIGNED Norman R. Freeman, Jr.			
ACTUAL SIGNATURE Norman R. Freeman, Jr.		PHYSICIAN'S NAME (Type) Norman R. Freeman, Jr.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/5/59	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Schmitt		ADDRESS 11 W 29th St - Baltimore	
24a. REC'D BY REGISTRAR SEP 8 '59		24b. REGISTRAR'S SIGNATURE Charles E. K...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

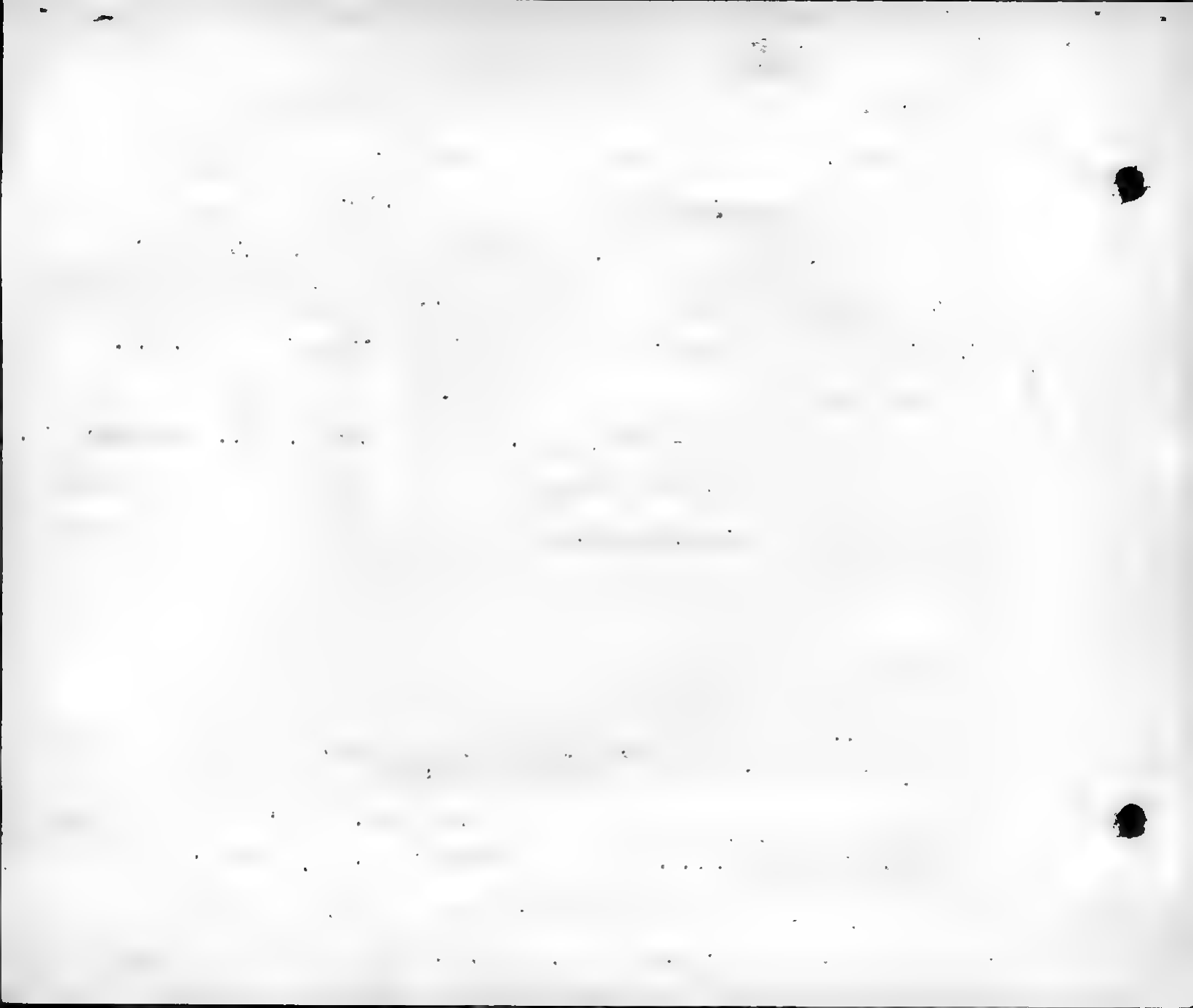
Reg. Dist. No.

10038

10016

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 10 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY 27 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne d. STREET ADDRESS 237 3rd Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First HIRAM Middle B. Last WAGNER		4. DATE OF DEATH Month September Day 20 Year 19 59	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH October 14, 1892
9 AGE (In years last birthday) yrs. 66		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe fitter	
10b. KIND OF BUSINESS OR INDUSTRY Railroad		11 BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12 CITIZEN OF WHAT COUNTRY? U. S.A.		13 FATHER'S NAME Samuel Wagner	
14. MOTHER'S MAIDEN NAME Laura Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I	
16. SOCIAL SECURITY NO. 705-05-2004		INFORMANT Address Clin. Records, VAH, Balto. 18, Md. Fort Howard Div.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 11, 1959 to September 20, 1959 and that death occurred at 11:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO, MD. FORT HOWARD DIVISION DATE SIGNED 9/21/59			
ACTUAL SIGNATURE David A. Oursler, M.D.		M.D. VAH, BALTO, MD. FORT HOWARD DIVISION	
PHYSICIAN'S NAME (Type) DAVID A. OURSLER, M.D.		VAH, BALTO, MD. FORT HOWARD DIVISION	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/23/59	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23 FUNERAL DIRECTOR'S SIGNATURE WTTZKE Funeral Home, 4101 Edmondson Ave., Balto. Md.		24a. REC'D BY REGISTRAR SEP 22 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur A. Kline	

MEDICAL CERTIFICATION



1

10039

10017

10039

CERTIFICATE OF DEATH

Reg. Dist. No.

10017

10039

CERTIFICATE OF DEATH

Reg. Dist. No.

10017

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				d. STREET ADDRESS 2825 MAUDLIN AVE			
3. NAME OF DECEASED (Type or print) First Middle Last ANNIE ESTELLE WAIN				4. DATE OF DEATH Month Day Year SEPT 11 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-22-1873	
9. AGE (In years last birthday) yrs 86		10. IF UNDER 1 YEAR Months Days Hours Min. 86		11. IF UNDER 24 HRS Months Days Hours Min. 86		12. IF UNDER 24 HRS Months Days Hours Min. 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME GEORGE E BASFORD				14. MOTHER'S MAIDEN NAME MAURA WREN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT Frank L. Smith Jr.				Address Cockeysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio DUE TO (b) Vascular Disease - Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 9 years							INTERVAL BETWEEN ONSET AND DEATH 9 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 10-17-49 , 19 49 , to 4-11 , 19 59 , that I last saw the deceased alive on 9-10 , 19 59 , and that death occurred at 12:53 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter T. Kees				ADDRESS (Street, city or town, state) Cockeysville, Md.			
DATE SIGNED 9/11/59							
PHYSICIAN'S NAME (Type) Walter T. Kees				Cockeysville, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-14-59		22c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE SEP 15 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 would be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10040

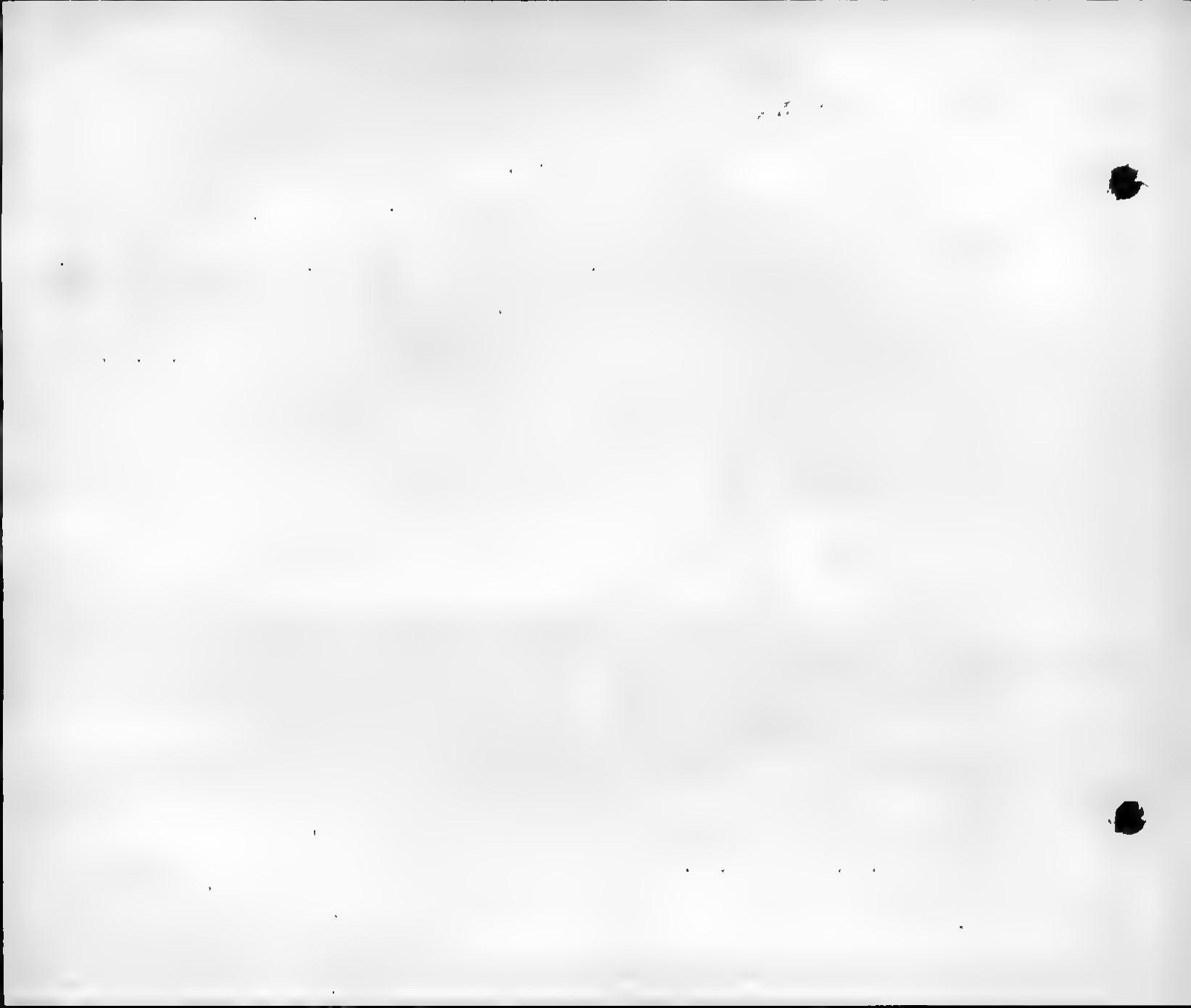
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 5Yrs. 11Mos. 27Dys.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION THE SHEPPARD AND ENOCH PRATT HOSPITAL		d. STREET ADDRESS 1520 Buchanan Street, N. W.	
3. NAME OF DECEASED (Type or print) First Frank Middle A. Last Walker		4. DATE OF DEATH Month September Day 14 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1872
9. AGE (In years last birthday) 86 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government Employee	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Vernon Walker		14. MOTHER'S MAIDEN NAME Susan Matilda Werninger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Chronic myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 7 yrs + 7 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Brain Syn. drome due to cerebral arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 17, 1953 to Sept. 14, 1959 , that I last saw the deceased alive on Sept. 12, 1959 , and that death occurred at 2:55 P. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED W. W. Elgin September 14, 1959			
ACTUAL SIGNATURE W. W. Elgin		M.D. September 14, 1959	
PHYSICIAN'S NAME (Type) W. W. Elgin, M. D.		The Sheppard and Enoch Pratt Hospital Towson, Md., Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Sept 15, 1959	22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee Wash. D. C.		24a. REG'D BY REGISTRAR DATE SEP 17 '59	24b. REGISTRAR'S SIGNATURE Charles L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

10041

Reg. Dist. No. 32

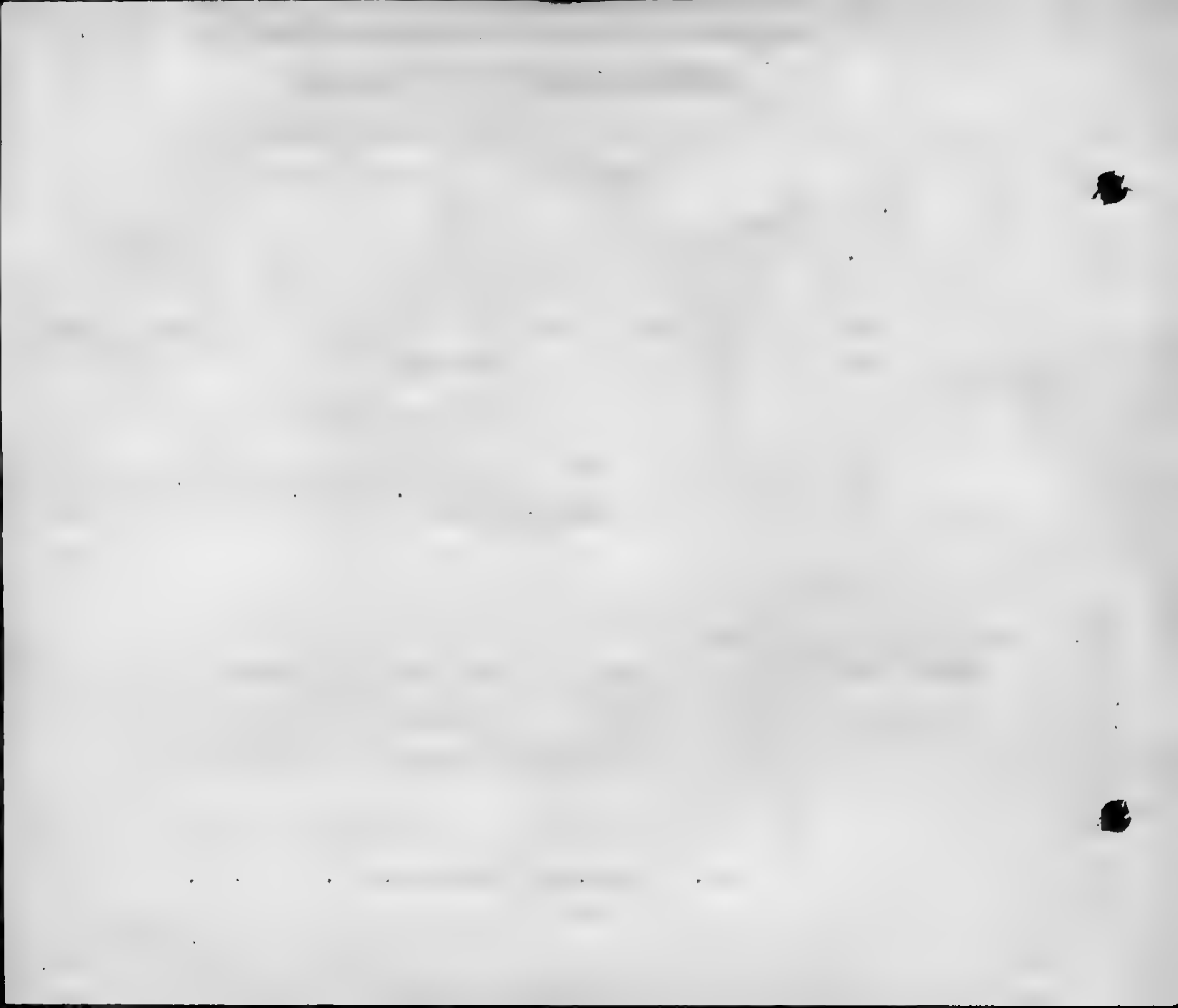
1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Baltimore	MARYLAND	STATE MARYLAND	COUNTY BALTIMORE
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Mt. Wilson	LENGTH OF STAY (In this place) 18 months	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN RURAL NEAR WOODLAWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mt. Wilson State Hospital		STREET ADDRESS (If rural give location) 6912 WINDSOR MILL RD	
3. NAME OF DECEASED (Type or Print) THEODORE		4. DATE OF DEATH (Month) (Day) (Year) Sept 10 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) DIVORCED	8. DATE OF BIRTH 11/26/18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AMBULANCE DRIVER		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 40 yrs.
11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LESLIE A. WILL SR.		14. MOTHER'S MAIDEN NAME BESSIE DEPEW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. 217-03-2673	
17. INFORMANT & ADDRESS Hospital Records		Mt. Wilson State Hospital	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
1. IMMEDIATE CAUSE (A) PULMONARY TUBERCULOSIS			6 years
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3/13 , 19 58 , to 9/10 , 19 59 , that I last saw the deceased alive on 7/10 , 19 59 , and that death occurred at 11:55 PM , from the causes and on the date stated above.			
SIGNATURE Wm. Newcomer		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 9/14/1959	
NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		LOCATION (City, town, or county) (State) Baltimore Maryland	
24. REC'D BY REGISTRAR SEP 14 '59		REGISTRAR'S SIGNATURE Carlton S. Frank	
FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		ADDRESS 4600 Liberty Hgts. Av	

INSTRUCTIONS

1 **24 hours** after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10020

10042

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr2mth19dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret E. Walter		4. DATE OF DEATH Month September Day 2 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 28, 1876
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME John Burk		14. MOTHER'S MAIDEN NAME Rachael Beckley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. None	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary abscesses DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Terminal bronchopneumonia DUE TO (c) Senile brain disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 21, 1959 , to Sept. 2, 1959 , that I last saw the deceased alive on Sept. 2, 1959 , and that death occurred at 9:40p M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 9-3-59			
ACTUAL SIGNATURE Stella Wachslar		PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-5-59	
22c. NAME OF CEMETERY OR CREMATORY Landon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fairley Funeral Home, Catonsville, Md.		24a. REC'D BY REGISTRAR DATE SEP 9 '59	
24b. REGISTRAR'S SIGNATURE Charles E. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10021

10043

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Bureau of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>MD.</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>805 WOODROW AVE.</u>		e. STREET ADDRESS <u>805 WOODROW AVE</u>	
3. NAME OF DECEASED (Type or print) <u>WALTERS, AUGUSTA</u>		4. DATE OF DEATH Month <u>9</u> - Day <u>1</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-99</u>
9. AGE (in years last birthday) <u>66</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-KEEPER</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>? WILKINSON</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>218-14-9950</u>		16. SOCIAL SECURITY NO <u>218-14-9950</u>	
17. INFORMANT <u>STELLA SIMMONS</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>			
420.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of Liver</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-5-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u>		24a. REC'D BY REGISTRAR <u>SEP 22 '59</u>	
ADDRESS <u>418 Eastern Blvd.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

Two for One. FilmG249 9-24-59 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10022

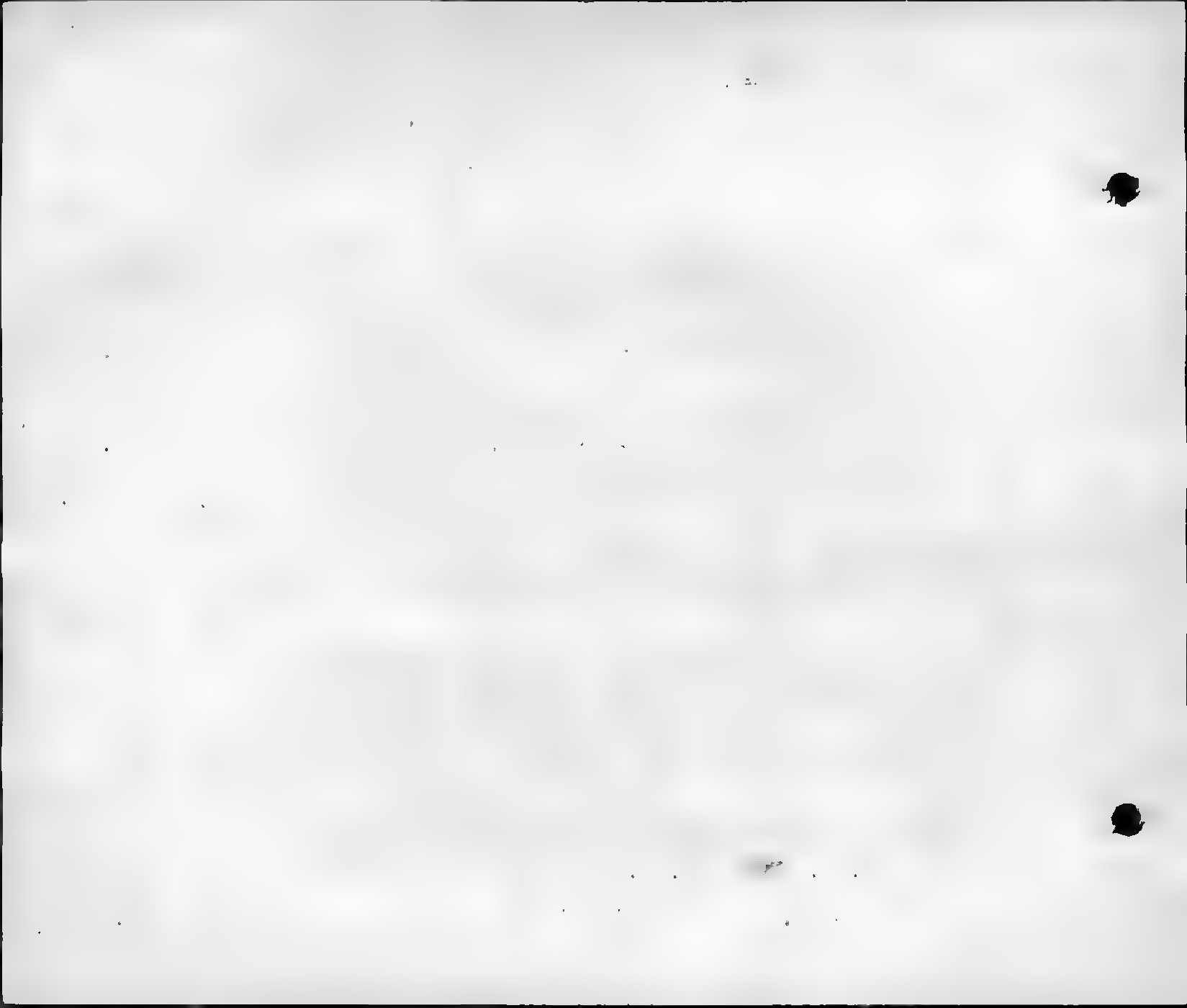
10044

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Lutherville</u>		c. LENGTH OF STAY IN 1b <u>Rural Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Lutherville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridgeway Road</u>			d. STREET ADDRESS <u>Ridgeway Road</u>		
3. NAME OF DECEASED (Type or print) First <u>Weltie</u> Middle <u>Edward</u> Last <u>Warner</u>			4. DATE OF DEATH Month <u>September</u> Day <u>23</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 28, 1892</u>	9. AGE (in years last birthday) <u>66</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper Route</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sunpapers</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Effran Warner</u>		
14. MOTHER'S MAIDEN NAME <u>Sarah Margaret weaver</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>1.0</u> <u>one</u>		
16. SOCIAL SECURITY NO. <u>212-32-4298</u>			17. INFORMANT <u>Mrs. Frances Warner, Ridgeway Rd.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>none</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I took charge of the removal described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>D. D. Caples</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-25-59</u>	
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 26, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Pikesville 8, Md.</u>		22e. REC'D BY REGISTRAR <u>Frank A. Newell</u>		22f. REGISTRAR'S SIGNATURE <u> </u>	
22g. DATE <u>OCT 5 '59</u>		22h. REGISTRAR'S SIGNATURE <u> </u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

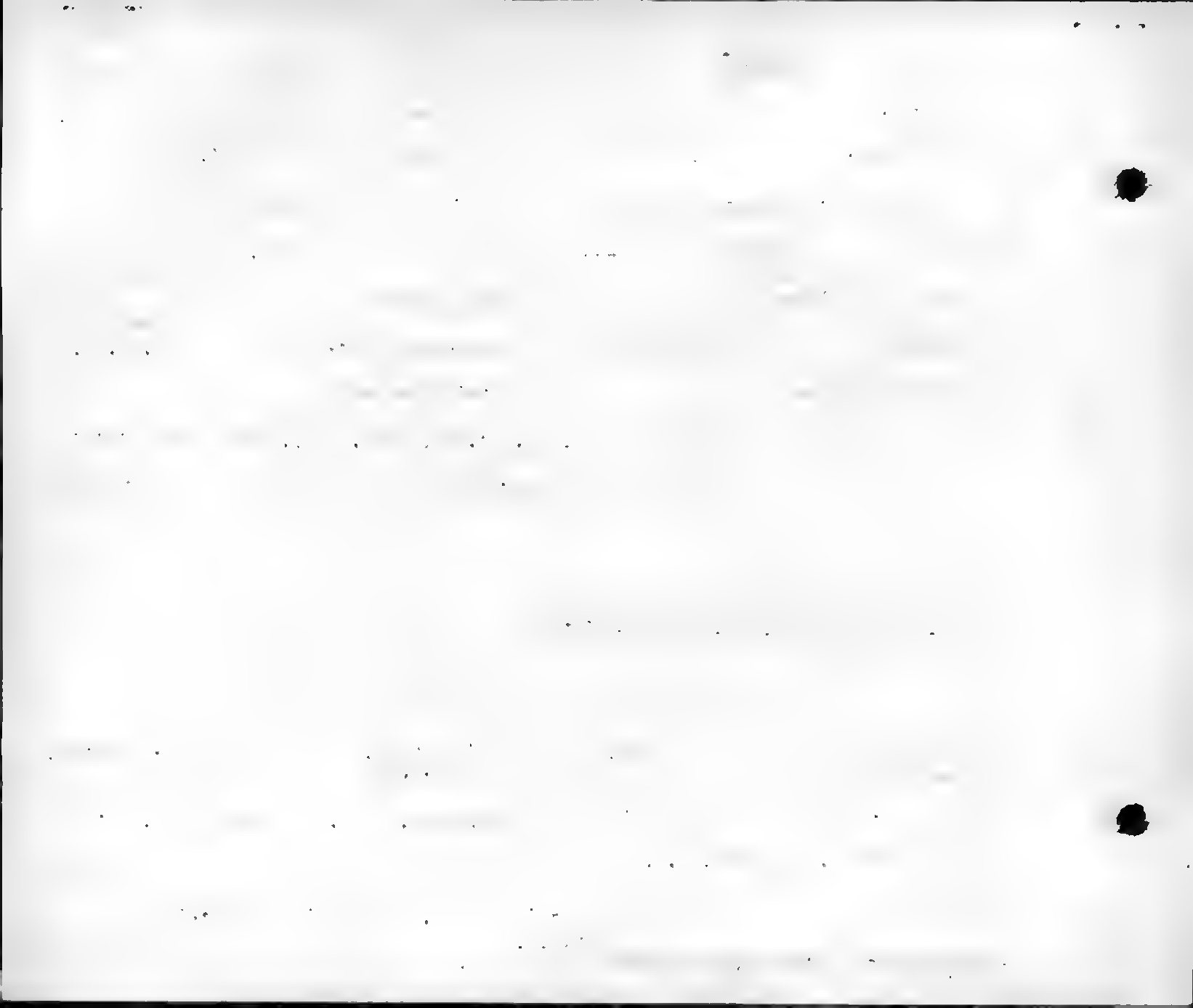
Reg. Dist. No.

10023

10045

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 49 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1204 Whatcoat Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT --- WARREN				4. DATE OF DEATH Month Day Year September 2 1959			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 19, 1896	9. AGE (In years last birthday) yrs 63	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Warrenton, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick Warren				14. MOTHER'S MAIDEN NAME Carrie Drummond			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO Unknown		INFORMANT Address Clin. Rec. VAH, Balto. 18, Md. Fort Howard Division			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE ESOPHAGUS 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 102X (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY TUBERCULOSIS, ARRESTED 1946 1957						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 15 , 19 59 , to Sept. 2 , 19 59 , and that death occurred at 4:50 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M.D. VAH, BALTO. 18, MD. FORT HOWARD DIV. 9/3/59							
ACTUAL SIGNATURE John W. Crawford PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/4/59		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington Phillips Funeral Home 1808-10 N. Monroe St. Baltimore 17, Md.				24a. REC'D BY REGISTRAR SEP 8 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kinn	

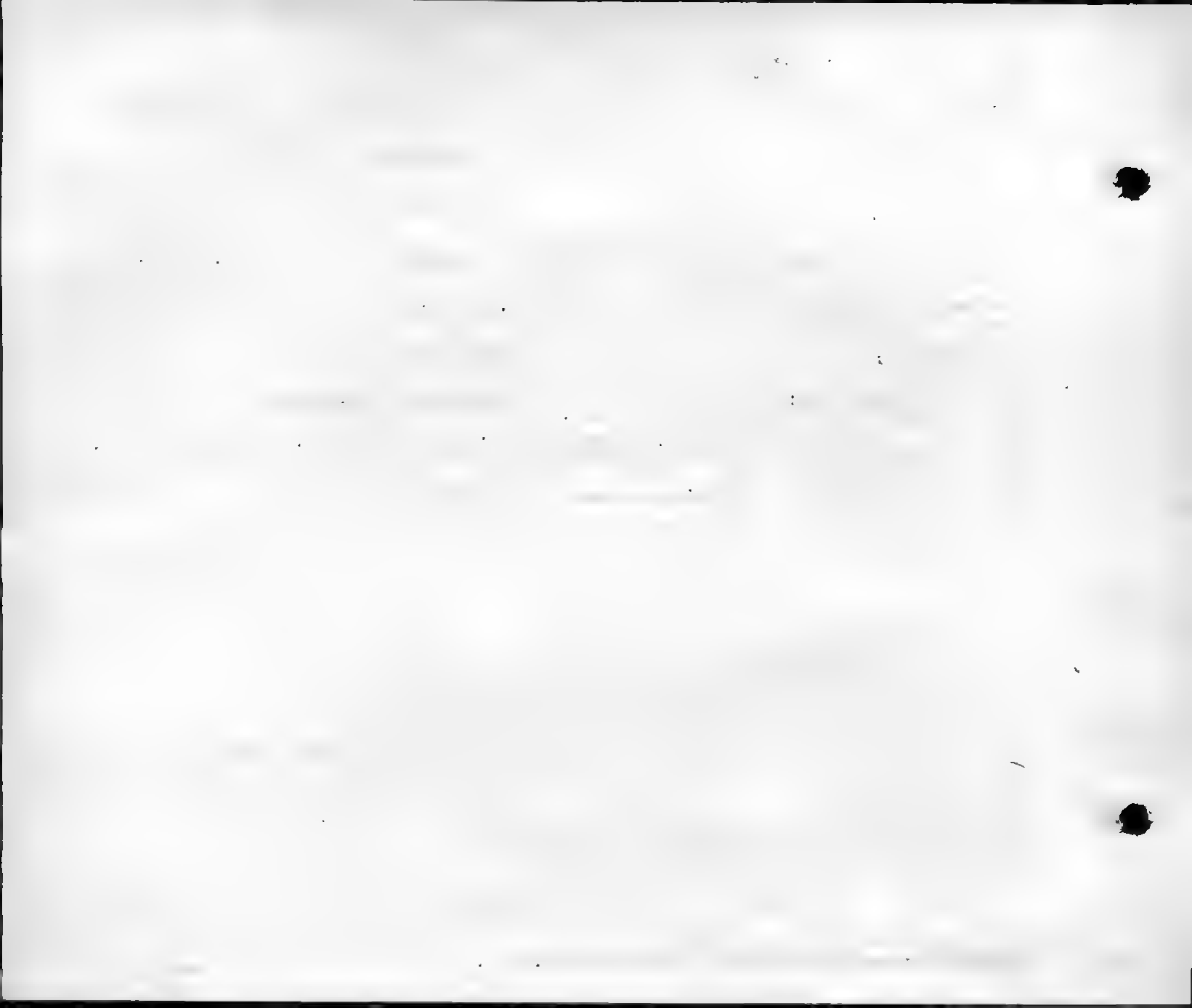
SHIPPED TO: McGuire Funeral Home, 9th & Westminster Sts Washington, D.C.



CERTIFICATE OF DEATH

VS A15 (4)
15M 9/5B

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2008 Mosby Avenue		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle ELEANOR Last WEIDMAN		4. DATE OF DEATH Month September Day 26 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1895
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip Weidman		14. MOTHER'S MAIDEN NAME Elizabeth Wallenwine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-03-8879	
17. INFORMANT Marie Barbara Hissey-2008 Mosby Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema 350x DUE TO Paralysis agitans (Parkinson's) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple atherosclerosis - from stress PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple atherosclerosis - from stress			
INTERVAL BETWEEN ONSET AND DEATH One hour			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan - 1949 to Sept. 26, 1959 , that I last saw the deceased alive on Sept 26, 1959 , and that death occurred at 4:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 209 Mosby Ave. Baltimore, Md. DATE SIGNED 1118 St. Paul St.			
ACTUAL SIGNATURE Wether Dore Foret		M.D. 1118 St. Paul St.	
PHYSICIAN'S NAME (Type) Wether Dore Foret			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/29/1959	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		ADDRESS 4600 Liberty Hgts. Ave.	
24a. REC'D BY REGISTRAR SEP 29 '59		24b. REGISTRAR'S SIGNATURE Wether Dore Foret	



CERTIFICATE OF DEATH

Reg. Dist. No.

10025

10047

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 3307 Dudley Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle W. Last WERNTZ		4. DATE OF DEATH Month September Day 20 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 29, 1883
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warrant Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army	
11. BIRTHPLACE (State or foreign country) Norristown, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Winfield Scott Werntz		14. MOTHER'S MAIDEN NAME Mary Brenner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I WW II 219-26-4867	
17. INFORMANT Clin. Records, VAH Balto. 18, Md., Ft. Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERIPHERAL VASCULAR COLLAPSE & PULMONARY EDEMA DUE TO ACUTE MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) ACUTE MYOCARDIAL INFARCTION DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Unknown 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) GEN. ARTERIOSCLEROSIS, CHRONIC BRAIN SYNDROME, RIGHT HEMIPARESIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 28 , 19 59 , to September 20 19 59 , and that death occurred at 4:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH Balto Md, Ft. Howard Div. 9/20/59			
ACTUAL SIGNATURE Harold R. Johnson		PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF SEPT. 24. 59	
22c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC. Baltimore Md.		24a. REC'D BY REGISTRAR SEP 24 '59	
24b. REGISTRAR'S SIGNATURE Charles J. Frank			

HENRY SANDER & SONS, INC. NORTH AVE & BROADWAY, BALTO., MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/58

100-100

10048

CERTIFICATE OF DEATH

Reg. Dist. No.

10026

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 87 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore (17) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (17) d. STREET ADDRESS 2009 Clifton Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle H. Last WHALEY		4. DATE OF DEATH Month September Day 24 Year 19 59	
5 SEX Male	6. COLOR OR RACE Colored	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 3, 1890
9. AGE (In years, lay, birthday) yrs. 69		10. IF UNDER 1 YEAR Months 8 Days 19	11. IF UNDER 24 HRS Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	11 BIRTHPLACE (State or foreign country) Salisbury, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James Whaley	
14. MOTHER'S MAIDEN NAME Mary Wooden		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I	
16 SOCIAL SECURITY NO 200-14-8425		INFORMANT Clinical Records, VAH, Baltimore, Md. Fort Howard	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY ABSCESES MULTIPLE, BILATERAL DUE TO (b) PULMONARY INFARCTS, INFECTED, MULTIPLE, BILATERAL DUE TO (c) MURAL THROMBOSIS, RIGHT AURICULAR APPENDAGE INTERVAL BETWEEN ONSET AND DEATH 6-8 WEEKS UNKNOWN UNKNOWN		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease, duration Unknown. Arteriosclerosis, marked, generalized, duration Unknown.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 29 , 19 59 , to September 24, 1959 , and that death occurred at 7:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, BALTO., MD., FT. HOWARD DIVISION DATE SIGNED 9/25/59			
ACTUAL SIGNATURE <i>John W. Crawford</i>		M.D. VAH, BALTO., MD., FT. HOWARD DIVISION	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.			
22a. BURIAL, CREMATATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 28, 59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		24a. REC'D BY REGISTRAR SEP 29 '59	
ADDRESS 1808-10 N. Monroe St. Balto.		24b. REGISTRAR'S SIGNATURE <i>Arthur A. Thomas</i>	

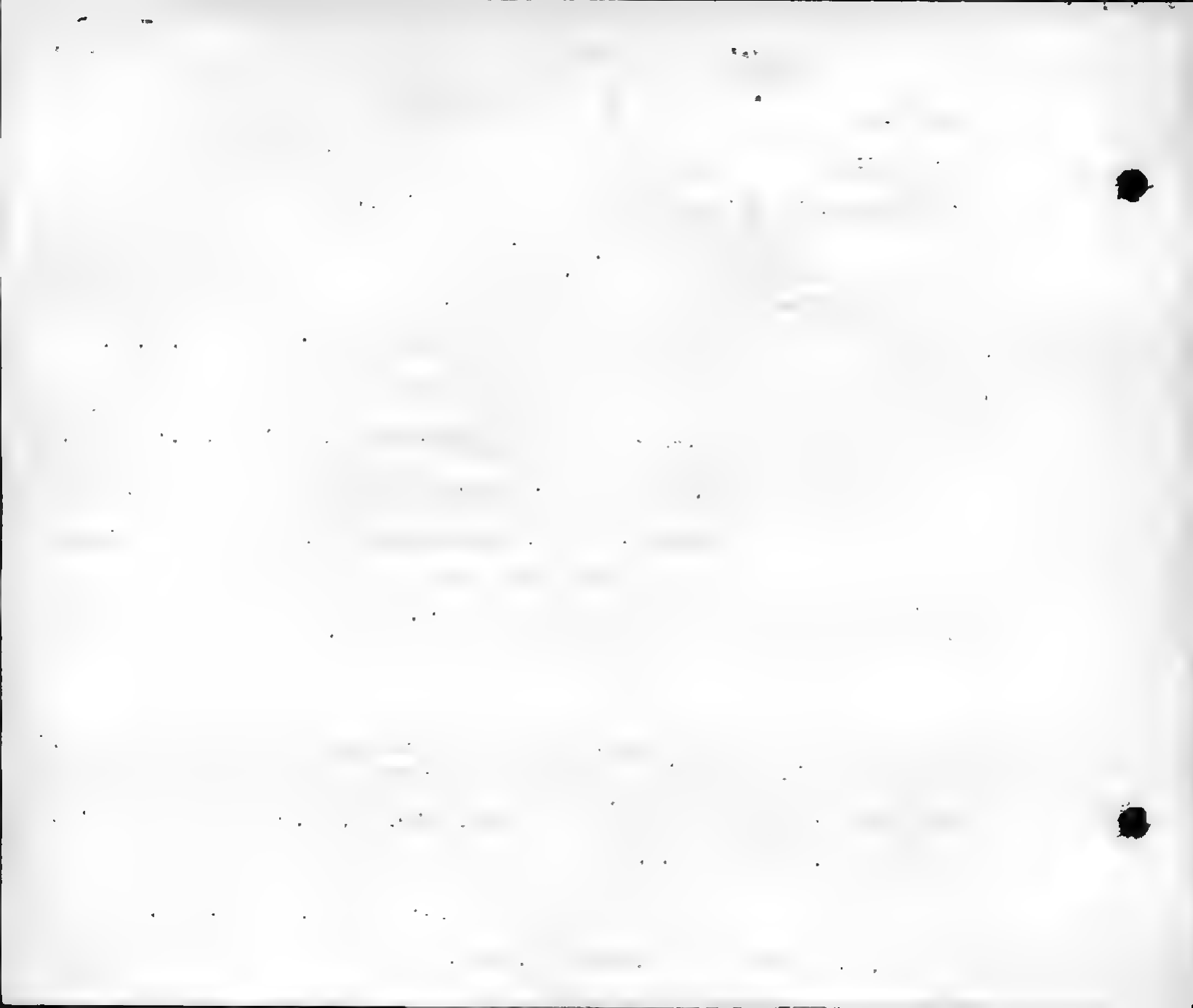
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4

may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10049

CERTIFICATE OF DEATH

Reg. Dist. No.

10027

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ISAAC</u> Middle <u>WHIPPLE</u> Last <u>WHIPPLE</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 27 1890</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JAMES WHIPPLE</u>				14. MOTHER'S MAIDEN NAME <u>LACRA BROWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>1959</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>8/17</u> , 19 <u>59</u> , to <u>9/10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/10</u> , 19 <u>59</u> , and that death occurred at <u>6:30</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>William Newcomer</u>				M.D. <u>Mt. Wilson, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D.</u>				Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-15-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keese</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 59</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10028

10059

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. George Co.			
b. CITY OR TOWN (If outside corporate limits, write BULFAL and give nearest town) Mt. Wilson,		c. LENGTH OF STAY IN TB 7-8 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital				d. STREET ADDRESS Route 2, Box 345			
3. NAME OF DECEASED (Type or print) First Henry Middle Ishmeal Last White				4. DATE OF DEATH Month 9 Day 2 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/10/02		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Fruit		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lee White				14. MOTHER'S MAIDEN NAME Jeanette Payne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Maryland Mt. Wilson State Hospital records, Mt. Wilson			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral broncho-pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis and Coronary artery disease INTERVAL BETWEEN ONSET AND DEATH 1 week						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None					
20c. TIME OF INJURY Month, Day, Year Hour None a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D.D. Caples, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-5-59		22c. NAME OF CEMETERY OR CREMATORY Beels Meth. Cemetery		22d. LOCATION (City, town, or county) (State) Camp Springs Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry B. B...		ADDRESS 1661-Good Hope Rd SE		24a. REC'D BY REGISTRAR SEP 8 '59		24b. REGISTRAR'S SIGNATURE Carlton L. H...	



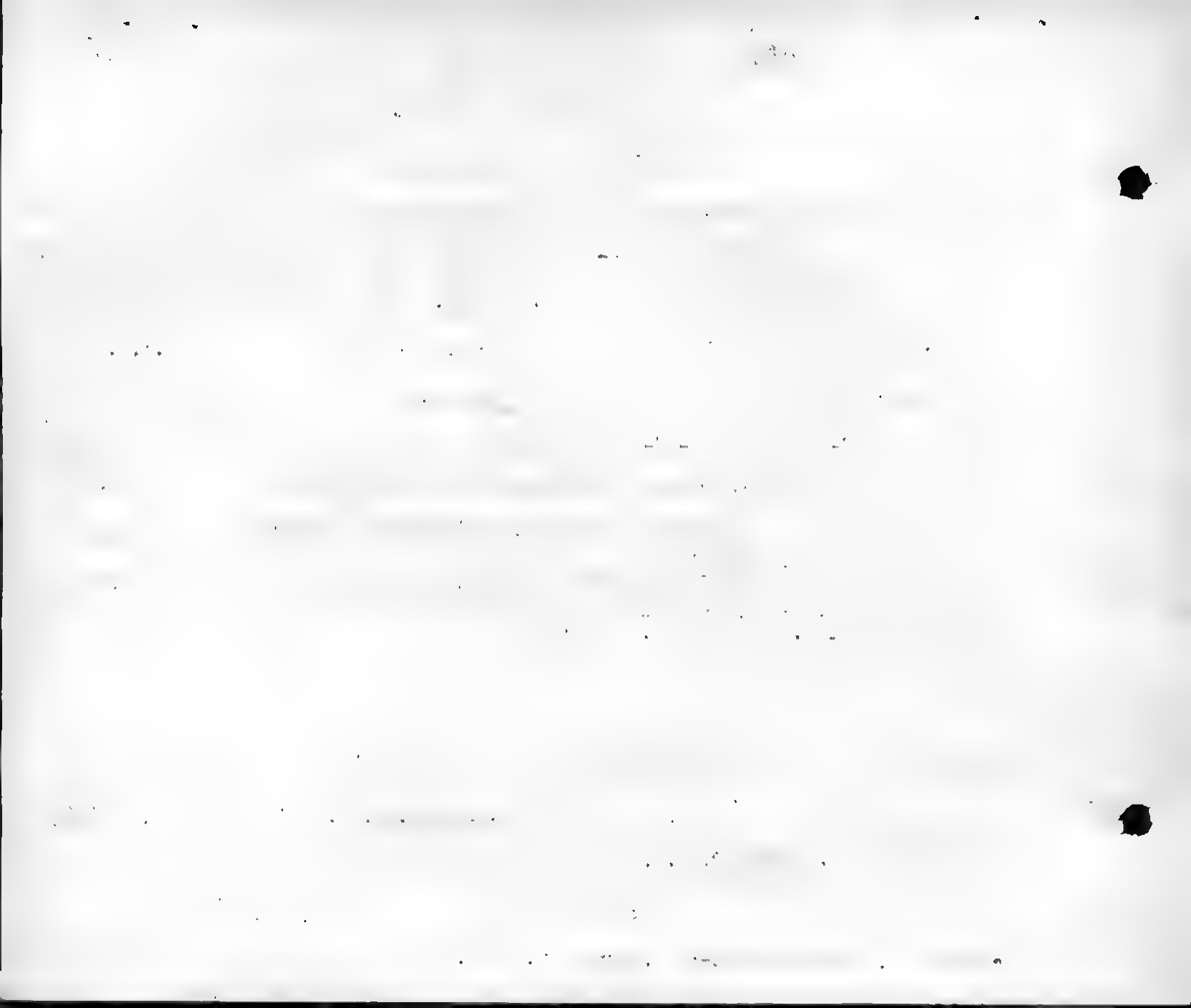
10051

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 11 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PETER Middle -- Last WHITE		4. DATE OF DEATH Month SEPTEMBER Day 30 Year 19 59	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1890
9. AGE (In years lost birthday) yrs 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LONGSHOREMAN	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MATTHEW WHITE		14. MOTHER'S MAIDEN NAME MARTHA BUSEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give war or dates of service) WW-1		16. SOCIAL SECURITY NO. 218-03-7347	
17. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EDEMA (RECENT) AND EMACIATION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) METASTATIC ADENOCARCINOMA, LIVER AND URINARY BLADDER (c) ARTERIOSCLEROSIS, MARKED, GENERALIZED		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC HEMORRHAGIC CYSTITIS - Duration unknown Surgical agcense, lower colon. Colostomy		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 20 , 19 59 , to Sept. 30 , 19 59 , and that death occurred at 5:10 p.m. , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTO. 18, MD. FORT HOWARD DIV. 10/1/59			
ACTUAL SIGNATURE John W. Crawford		M.D. VAH, BALTO. 18, MD. FORT HOWARD DIV. 10/1/59	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF 10/4/59	22c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial	22d. LOCATION (City, town, or county) (State) Baltimore / Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		ADDRESS 1808-10 N. Monroe St. Balto. Md.	
24a. REC'D BY REGISTRAR Oct 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09907 items 7, 22 Film 6247 10-1-59 et

10030

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5536 Selma Ave</u>				e. STREET ADDRESS <u>5536 Selma Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Randall</u> Middle <u>E.</u> Last <u>White</u>				4. DATE OF DEATH <u>9-26-59</u> Month <u>9</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1910</u>	9. AGE (in years last birthday) <u>49</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>		11. BIRTHPLACE (State or foreign country) <u>Cambridge Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ira White</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>213 07 4086</u>		17. INFORMANT <u>Ella White 5536 Selma Ave</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <u>Sept. 28, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hubbard Funeral Home, 4107 Wilkins Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 30 59</u>		24b. REGISTRAR'S SIGNATURE <u>Orlando J. Harris</u>	

Balto. 29



10052

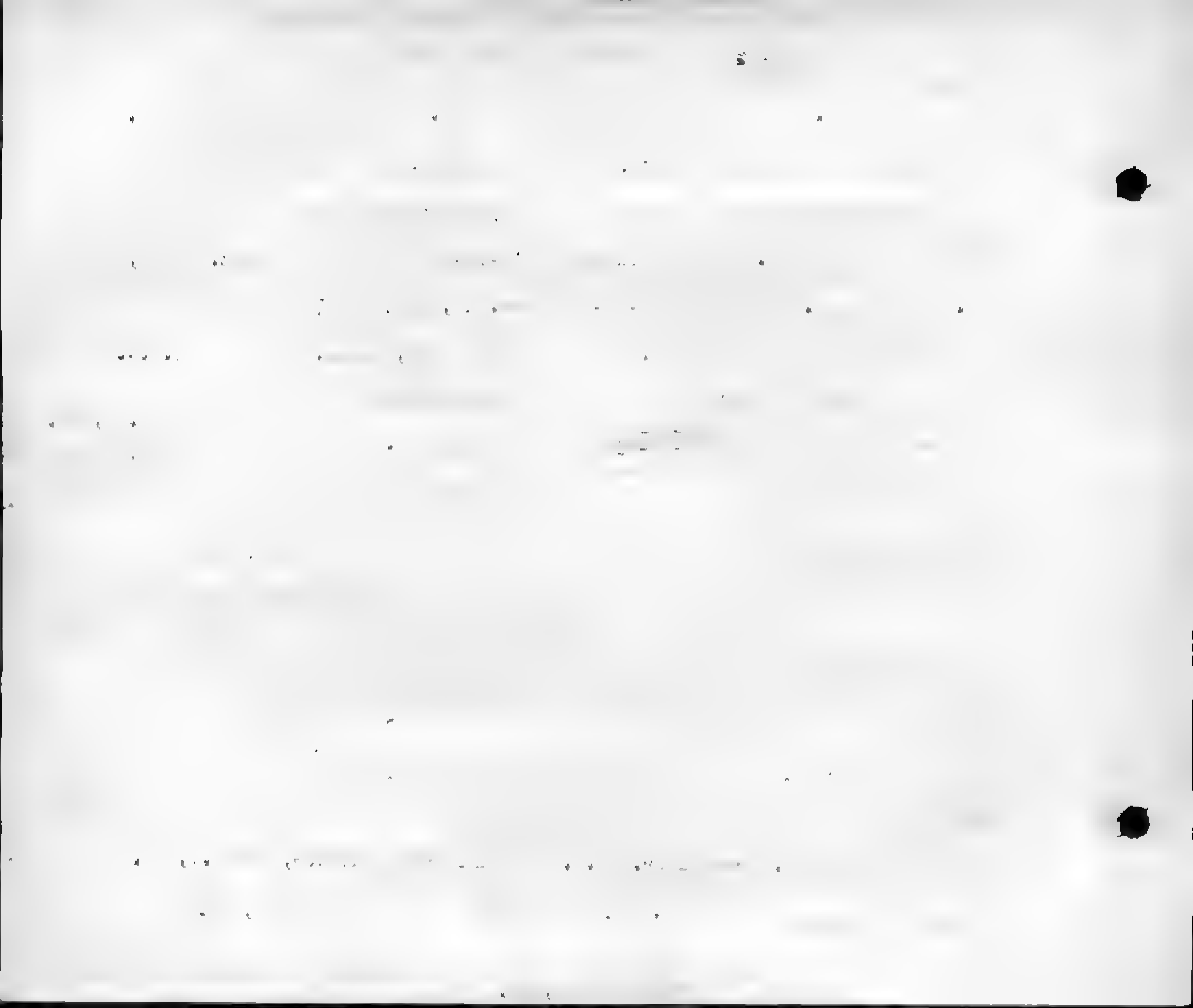
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN TB Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3022 Rolling Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn	
3. NAME OF DECEASED (Type or print) First R. Middle Milburn Last Widerman		4. DATE OF DEATH Month Sept. Day 17, Year 19 59	
5. SEX M.	6. COLOR OR RACE W.	7. ***** WIDOWED	8. DATE OF BIRTH Feb. 17, 1886
9. AGE (In years last birthday) yrs 73		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Bldg.	
11. BIRTHPLACE (State or foreign country) Woodlawn, Balto. 7		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Widerman		14. MOTHER'S MAIDEN NAME Sally Ritter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) *****		16. SOCIAL SECURITY NO. 215-03-4348	
17. INFORMANT Miss Margaret E. Widerman		Address Balto. 7, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PROSTATE GLAND WITH METASTASES 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 y	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) *****	
20c. TIME OF INJURY Month, Day, Year Hour m. p. m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) *****	20f. (City or town) (County) (State) *****
21. I certify that I attended the deceased from 19 12 to September , 19 59 , that I last saw the deceased alive on September 16, 19 59 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Millard T. Traband Jr. M.D.		DATE SIGNED 9/18/59	
PHYSICIAN'S NAME (Type) Millard T. Traband Jr. M.D.		5101 Gwynn Oak Ave, Balto. 7, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/19/59	22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	22d. LOCATION (City, town, or county) (State) Randallstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Spring Byers		24a. REC'D BY REGISTRAR DATE SEP 22 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Kraus
ADDRESS 8728 Liberty Road		Randallstown, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10053

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 5	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6 W. BURKE AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHRISTIAN Middle WILL Last WILL		4. DATE OF DEATH Month SEPTEMBER Day 11 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 24, 1895
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR Months 8 Days 17 Hours 14 Min 10	11. IF UNDER 24 HRS Hours 14 Min 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUILDER-RETIRED		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN WILL		14. MOTHER'S MAIDEN NAME SOPHIE GARMER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or date of service) NONE		16. SOCIAL SECURITY NO. 214-34-2602	
17. INFORMANT FAMILY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 160X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes DUE TO (c) Arteriosclerosis 10X10 10YRS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 160X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 2 , 1959, to Sept 11 , 1959, that I last saw the deceased alive on Sept 11 , 1959, and that death occurred at 10:30 P. M. from the causes and on the date stated above			
ACTUAL SIGNATURE Carl F. Benson, M.D.		ADDRESS (Street, city or town, state) 5111 York Rd Baltimore, Md	
PHYSICIAN'S NAME (Type) CARL F. BENSON, M.D.		DATE SIGNED SEP 11 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF SEPT. 14, 1959	22c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEM.	22d. LOCATION (City, town, or county) (State) TOWSON, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John Burns, Sr., Towson, Md.		24a. REC'D BY REGISTRAR DATE SEP 14 '59	24b. REGISTRAR'S SIGNATURE Charles S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10054

CERTIFICATE OF DEATH

Reg. Dist. No.

10033

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cockeysville		c. LENGTH OF STAY IN TB life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Warren Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jesse Middle Nickles Last Williams		4. DATE OF DEATH Month 9 Day 12 Year 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-15-1877
9. AGE (In years last birthday) yrs. 82		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) watchman		10b. KIND OF BUSINESS OR INDUSTRY railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jake Williams		14. MOTHER'S MAIDEN NAME Stauffer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) ???	
17. INFORMANT Mrs. H. Benson Bareham,		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) Gen. Arteriosclerosis DUE TO (c) Carcinoma Stomach & Liver Metastases			INTERVAL BETWEEN ONSET AND DEATH 5 yrs ? 6 yrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 1954 to Sept. 12, 1959 that I last saw the deceased alive on Sept. 12, 1959 and that death occurred at 3:30 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED 3105 N. Charles St. Baltimore, Md. 18-716			
ACTUAL SIGNATURE Robt. H. Siver		M.D. 3105 N. Charles St. Baltimore, Md. 18-716	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-14-59	22c. NAME OF CEMETERY OR CREMATORY Jessops Methodist	22d. LOCATION (City, town, or county) (State) Sparks, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.		24a. REC'D BY REGISTRAR DATE SEP 15 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

10034

Reg. Dist. No.

10055

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rodgers Forge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>217 Rogers Forge Road</u>		d. STREET ADDRESS <u>1217 Rodgers Forge Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Williams</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 1 - 1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Men's Clothing</u>	
11. BIRTHPLACE (State or foreign country) <u>Gardiff, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Thomas J Williams</u>		14. MOTHER'S MAIDEN NAME <u>Mary Parry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>160-09-0010</u>	
17. INFORMANT <u>Mrs Edna Williams</u>		Address <u>217 Rodgers Forge Road Baltimore Md 12</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>BRONCHO-PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>6 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>SEPT. 8, 1959</u> to <u>SEPT. 12, 1959</u> , that I last saw the deceased alive on <u>SEPT. 12, 1959</u> , and that death occurred at <u>8:30</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Arthur Karfquin</u> M.D.		PHYSICIAN'S NAME (Type) <u>ARTHUR KARFQUIN</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Sept 15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air Harford Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Stiles</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 16 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.



10056

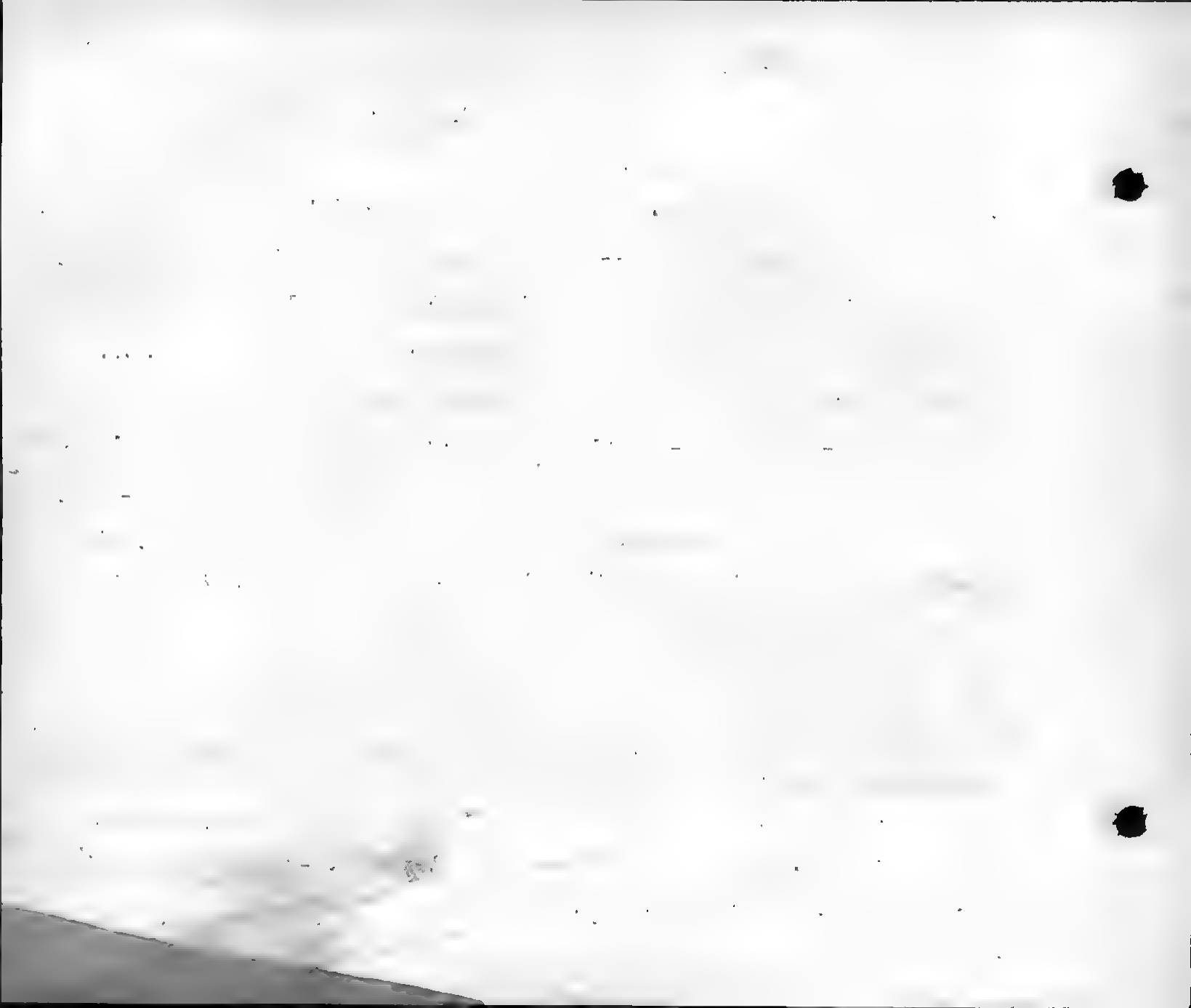
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 1b 82 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 2016 ORLEANS STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RICHARD Middle -- Last WILLIAMS		4. DATE OF DEATH Month SEPTEMBER Day 19 Year 19 59	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 4 1888
9. AGE (in years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRACKMAN		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
11. BIRTHPLACE (State or foreign country) COLLINGTON MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS WILLIAMS		14. MOTHER'S MAIDEN NAME MARIA TYLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-1		16. SOCIAL SECURITY NO 216-05-0991	
17. INFORMANT CLIN REC VET ADM HOSP BALTIMORE MD		Address Ft. Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE HEART FAILURE 150x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) PNEUMOTHORAX DUE TO (c) ESOPHAGEAL RESECTION FOR CARCINOMA OF ESOPHAGUS			INTERVAL BETWEEN ONSET AND DEATH 1-1/2 HRS 5 DAYS 1 YEAR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from June 29 , 19 59 , to September 19 , 19 59 , and that death occurred at 6:15 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 9-19-59			
ACTUAL SIGNATURE Wane 6:15 4 10. M.D. VAH BALTIMORE MD-FT HOWARD DIVISION		PHYSICIAN'S NAME (Type) DANIEL R. ZOLL MD VAH BALTIMORE MD-FT HOWARD DIVISION	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-23-59	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY BALTIMORE MARYLAND		22d. LOCATION (City town or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O Wilson Funeral Home		24a. REC'D BY REGISTRAR SEP 21 '59	
24b. REGISTRAR'S SIGNATURE 6:15 PM 9-21-59			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



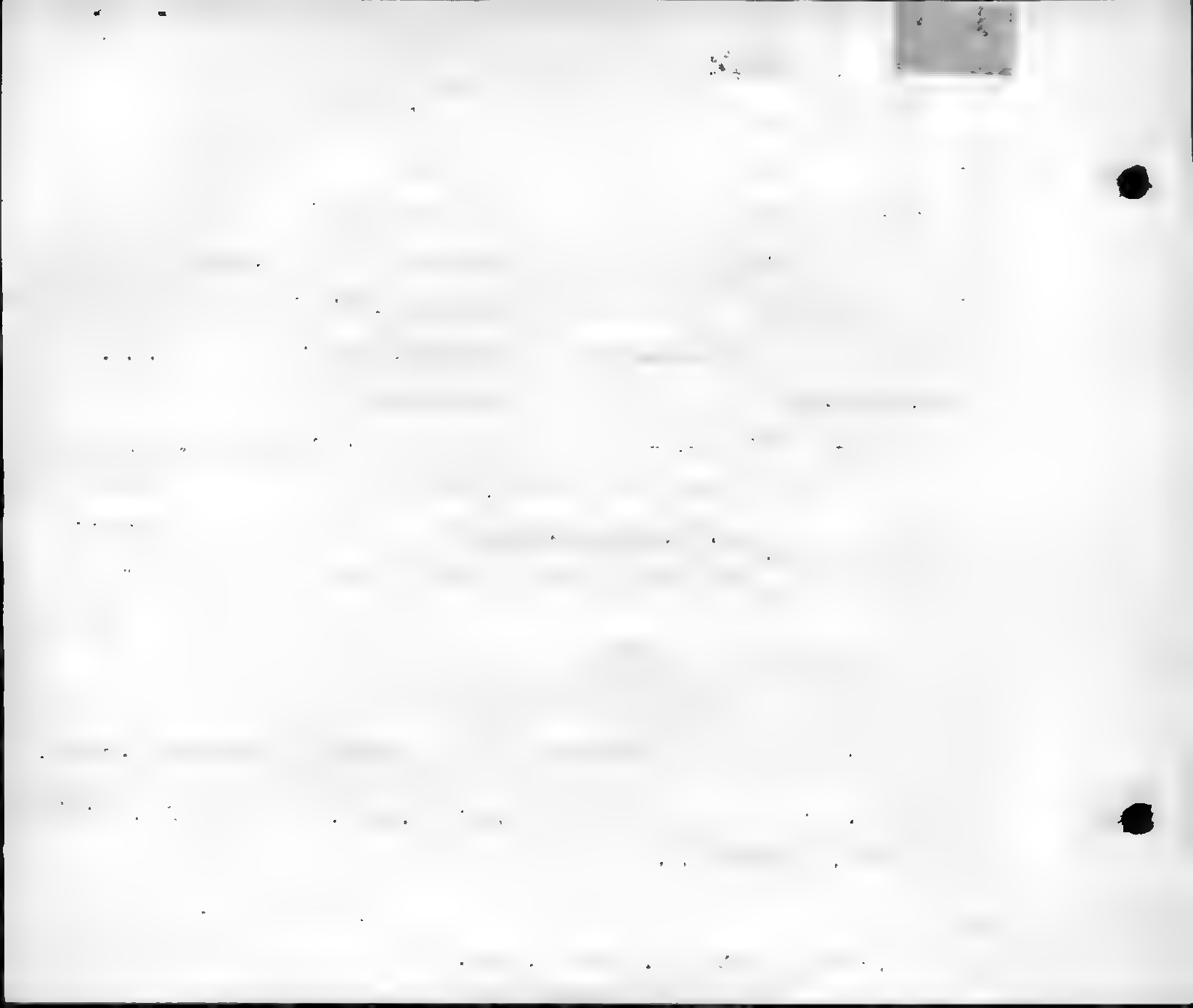
10057

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 9 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE (16)	
f. STREET ADDRESS 3510 DUVAL AVENUE		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RUFUS -- WILLIAMS JR		4. DATE OF DEATH Month Day Year September 30 19 59	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 10, 1928
9. AGE (In years lost birthday) yrs 31		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY BUSINESS SCHOOL	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RUFUS WILLIAMS SR		14. MOTHER'S MAIDEN NAME LEOLIA BRIGHT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. PL-28 Korean 211-24-2439	
17. INFORMANT CLIN REC VAH BALTIMORE MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) UREMIA AND PULMONARY EDEMA 592x DUE TO (b) CHRONIC GLOMERULONEPHRITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) HYPERTENSIVE CARDIOVASCULAR DISEASE			
INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 21, 19 59 to September 30 19 59 , that he was deceased on September 30 19 59 and that death occurred at 6:22 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTO. 18, MD. FORT HOWARD DIV. 10/1/59			
ACTUAL SIGNATURE John W. Crawford		M.D. VAH, BALTO. 18, MD. FORT HOWARD DIV. 10/1/59	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/3, 59	22c. NAME OF CEMETERY OR CREMATORY Mount Auburn	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		24a. REC'D BY REGISTRAR OCT 6 1959	
ADDRESS 1808-10 N. Monroe St. Balto. Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10058

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville 4</u>				c. LENGTH OF STAY IN 1b <u>3 yrs. 70 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor Home for Aged</u>				d. STREET ADDRESS <u>Stevenson, Md.</u>			
3. NAME OF DECEASED (Type or print) <u>Josephine</u> First <u>Wilson</u> Middle Last				4. DATE OF DEATH <u>Sept - 9 - 1959</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-28-1864</u> 95 yrs	
9. AGE (In years last birthday) <u>95</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Phila. Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Joseph Donahue</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Donahue</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>None</u>			
17. INFORMANT <u>Mr. Charles A. Wilson, Jr.</u>				Address <u>Maryland Stevenson Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>450.0</u> DUE TO Condition, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>gout arthritis - sclerotic</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>20 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>36</u> , to <u>Sept 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 4</u> , 19 <u>59</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1725 Reisterstown Rd. Pikesville, Md.</u> DATE SIGNED <u>Sept 9, 1959</u>							
ACTUAL SIGNATURE <u>Palmer Williams</u>				PHYSICIAN'S NAME (Type) <u>Palmer Williams, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Sept. 10, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Laurel Hill</u>	
22d. LOCATION (City, town or county) (State) <u>Bala-Cynwid, Pennsylvania</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>				24a. REC'D BY REGISTRAR <u>SEP 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10038

10059

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN Tb X Woodlawn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY SIMPERS TIMANUS WINDSOR		4. DATE OF DEATH Month Day Year September 28 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1878
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Woodlawn, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Mary George Timanus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Charlotte W. Tyson		Address Borham Landing Rd. Morristown, N.J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 days ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/8/59 19 to 9/28/59 19, that I last saw the deceased alive on 9/27/59 19, and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6410 Windsor Mill Rd DATE SIGNED Arthur J. Kneass			
ACTUAL SIGNATURE Milton Schlens		M.D. M.D.	
PHYSICIAN'S NAME (Type) Milton Schlens			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 10/1/1959	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		22d. LOCATION (City, town, or county) (State) Randallstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		ADDRESS 4600 Liberty Hghts. Ave.	
24a. REC'D BY REGISTRAR OCT 1 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10060

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>56 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>SPRING GROVE STATE HOSP</u>		d. STREET ADDRESS <u>1231 W. LOMBARD ST.</u>	
3. NAME OF DECEASED (Type or print) <u>MIHEL (Mikol) ZEPRESKO</u>		4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 12 1881</u>
9. AGE (in years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roller maker B & O. R. R.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HUNGARY</u>	
11. BIRTHPLACE (State or foreign country) <u>HUNGARY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>HOSPITAL'S RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Obstructive hydronephrosis</u> DUE TO (c) <u>Carcinoma of Prostate with regional metastases</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>111X</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 4, 1959</u> , to <u>Sept. 6, 1959</u> , that I last saw the deceased alive on <u>Sept. 6, 1959</u> , and that death occurred at <u>10:35 p. m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Spring Grove St. Hosp.</u> DATE SIGNED <u>9/7/59</u>			
ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D.		PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/9/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem</u>		22d. LOCATION (City, town, or county) (State) <u>4300 Old Frederick Rd.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Lewandowski</u> ADDRESS <u>Balto, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 8 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any conditions are necessary, please call the Director, Page 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Use pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Item 18 Film 250 10-2 **MARYLAND STATE DEPARTMENT OF HEALTH**
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
0990 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10040

1. PLACE OF DEATH
a. COUNTY **Baltimore** **MARYLAND**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Dundalk**
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE **Md.** b. COUNTY **Baltimore**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Dundalk**
d. STREET ADDRESS **531 Eastern Blvd.** e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) **Peter** **Ziarnowski**
4. DATE OF DEATH **Sept. 26, 1959**
5. SEX **M** 6. COLOR OR RACE **wh** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH **Apr. 29, 1916** 9. AGE (In years last birthday) **43** 10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) **Baltimore Maryland** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Alexander Ziarnowski** 14. MOTHER'S MAIDEN NAME **Antoinette Schultz**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **Yes WW 2** 16. SOCIAL SECURITY NO. **?** 17. INFORMANT **Theodore Ziarnowski-1005 W. Baltimore St.** Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: **Arteriosclerotic heart disease**
IMMEDIATE CAUSE (a) **420.0** DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:
INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

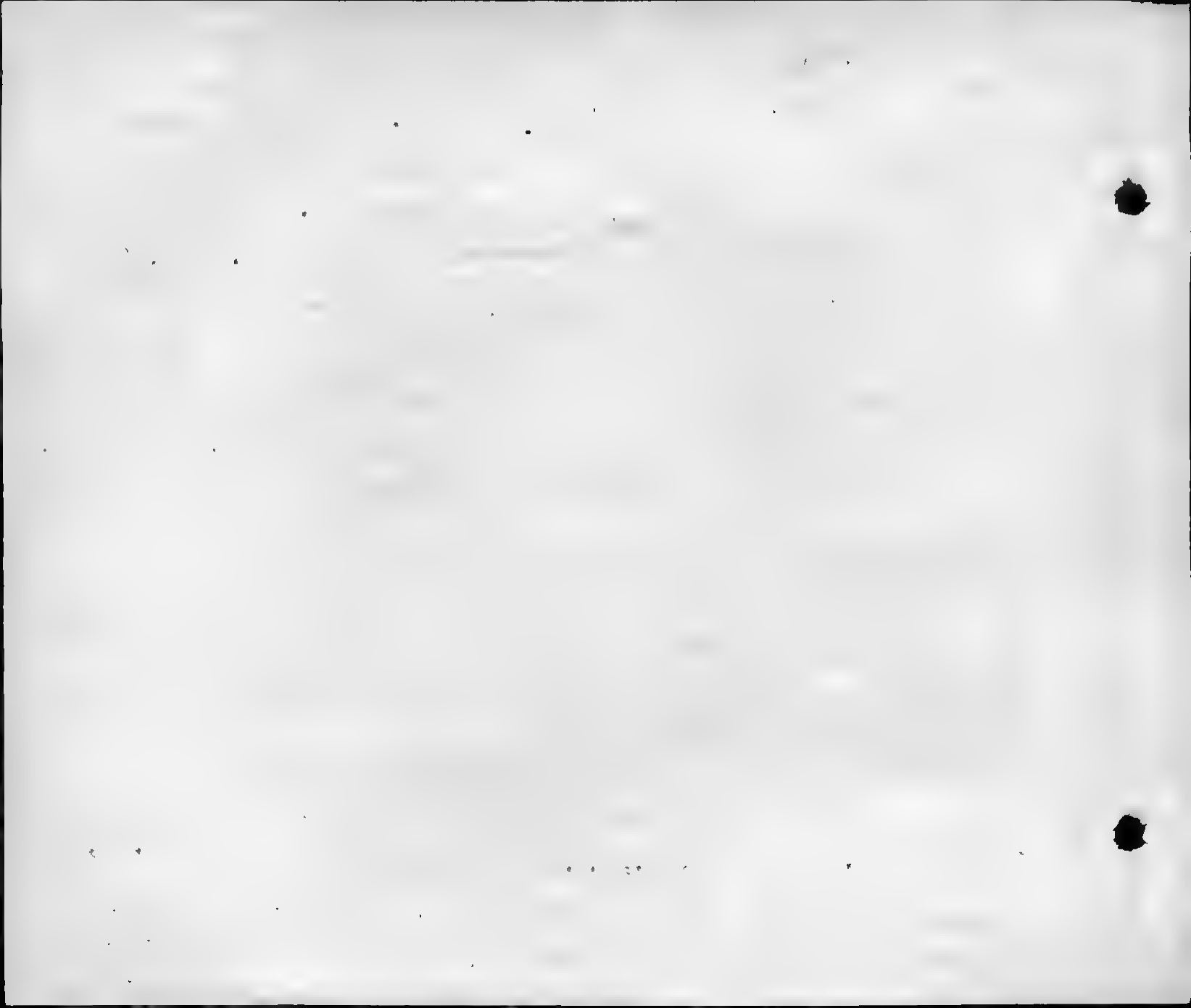
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **W. Bradley King, Jr., M.D.** CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ DEPUTY MEDICAL EXAMINER ☐ DATE SIGNED **Sept. 27, 1959**

EXAMINER'S NAME (Type) **W. Bradley King, Jr., M.D.** Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **10/26/1959** 22c. NAME OF CEMETERY OR CREMATORY **Baltimore National Cem.** 22d. LOCATION (City, town, or country) (State) **Baltimore Maryland**

23. FUNERAL DIRECTOR **Ellsworth Armacost** ADDRESS **Ellsworth Armacost-4600 Liberty Heights Ave.** 24a. REC'D BY REGISTRAR **OCT 5 '59** 24b. REGISTRAR'S SIGNATURE **Arthur J. Thomas**



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10041

Reg. Dist. No.

10061

1. PLACE OF DEATH a. COUNTY Parkton, Balto. Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Balto., Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) York Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GRAND First ELIZABETH Middle ZINN Last				4. DATE OF DEATH SEPT. 15 Month Sept. Day 15 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-1-1892	
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Hughes				14. MOTHER'S MAIDEN NAME Marietta Donehew			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Henry D. Scarberry Address York Rd., Parkton			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 hrs.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE A. M. France				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) A. M. FRANCE				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-25-59		22c. NAME OF CEMETERY OR CREMATORY Mt. Alto Baptist Cem.		22d. LOCATION (City, town, or county) (State) Mount Alto W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Brook's Funeral Service				ADDRESS 622 York Rd.		24a. REC'D BY REGISTRAR DATE SEP 18 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. House			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
John Doe		45		Male		White	
Residence		Occupation		Cause of Death		Manner of Death	
123 Main St, Boston		Teacher		Heart Disease		Natural	
Date of Death		Time of Death		Place of Death		Physician	
10-1-19		10:30 AM		Home		Dr. Smith	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	
Witness		Witness		Witness		Witness	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Burial		Time of Burial		Place of Burial		Burial Officer	
10-1-19		11:00 AM		Cemetery		[Signature]	
Burial Officer		Burial Officer		Burial Officer		Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	

10062

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22		c. LENGTH OF STAY IN 1b 55 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6812 YOUNGSTOWN AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) STANISLAUS ZOMKOWSKI		4. DATE OF DEATH SEPTEMBER 26, 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 30, 1885
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOULDER		10b. KIND OF BUSINESS OR INDUSTRY WEISKITTEL	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FRANCIS ZOMKOWSKI		14. MOTHER'S MAIDEN NAME MARY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-16-5388	
17. INFORMANT MR. BOLES LAUS ZOMKOWSKI		Address 1107 DUNDALK AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 10 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from SEPT. 9, 1957 to 9/26, 1959 , that I last saw the deceased alive on 9/26, 1959 , and that death occurred at 9:40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. E. Baermann M.D.		DATE SIGNED DR. W. E. BAERMANN	
PHYSICIAN'S NAME (Type) Dundalk 22, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF OCT. 1, 1959	22c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY	22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Raymond L. Kacprowski		24a. REC'D BY REGISTRAR 2525 FLEET ST.	
24b. REGISTRAR'S SIGNATURE Oct 6 '59			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

